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ABSTRACT

The purpose of this book is to attempt to forecast the future of professional counseling as it transitions into the next millennium. It is designed to help professional counselors understand and prepare for future changes in the profession of counseling. Understanding the rationale and observable predictors of anticipated changes meaningfully facilitates and enriches the efficiency and effectiveness of professional counseling services. The expertise of professional counselors, counselor educators, and scholars throughout the United States and abroad was enlisted in order to complete the task of writing this book. Some of the projections herein are supported by statistical and empirical data. However, many others are based on the knowledge, personal experience, intuitions, and gut feelings of professionals throughout the counseling community. Chapters include: (1) "Professional Counseling: Evolution, Current Status, and Beyond" (Rollins, Garcia, and Thomas); (2) "Managed Care and Privatization in Counseling and Rehabilitation" (Alston and Harley); (3) "Special Technology for the Next Millennium" (Riggar and Janikowski); (4) "Assistive Technologies" (Falvo); (5) "Ethical Issues in the 21st Century" (Patterson); (6) "Future Trends in Selected Systems" (Arnaldi and Simon); (7) "Emerging Populations and Issues in the Next Millennium" (Dixon, Amuso, and Stozier); (8) "Diversity Watch for the New Millennium: Reversing the Tide of Exclusion" (Stadler, Middleton, and King); (9) "International Vistas for Counseling" (Leung and Emener); and (10) "The Human Side of Health Care in the New Millennium" (Janes and Emener). (Each chapter contains an extensive list of references, 328 references overall. Includes author and subject indexes.) (GCP)

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PROFESSIONAL COUNSELING
Transitioning into the Next Millennium

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PROFESSIONAL COUNSELING

Transitioning into the Next Millennium

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This book is dedicated to
our respective significant others
Charlie L. and Jenny V.

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FOREWORD

I am honored to be writing the foreword for the first book on professional counseling of the new millennium. This book comes at a momentous time in human history and a crucial point in the development of counseling as a profession. As the profession of counseling enters the 21st century and its second 100 years of existence, it is faced with major challenges to its primary mission of facilitating human development through offering help with problem resolution or decision making. Both forces external to and within the profession are forcing us to reconsider traditional concepts about the art and science of counseling. Daily, counselors find themselves questioning their answers about the theory and practice of the profession.

Professional Counseling: Transitioning into the Next Millennium provides us with a new set of answers while posing provocative new questions for the practice of counseling in the new century. The chapter contributors, who have obviously "thought outside the box" about their topics, give us a new way of looking at our practice as professional counselors in this uncharted, but potentially exciting, world of the nascent millennium. Counseling practice is going to be profoundly affected by major changes in how we manage health care, rapidly changing technology, a broader appreciation for all aspects of human diversity, and increasing global interconnectedness. This book makes clear that 20th century counseling paradigms will have, at best, limited validity in the 21st century, and if we are going to continue to move our proud tradition as helpers forward, we must take serious heed of the implications for practice presented herein.

I am happy to say that this is not just another "introduction to the profession of counseling" text. The contributors make a significant new contribution to the counseling literature. Rather than rehashing what we already know about important aspects of the profession, this book takes us to where we have not been in terms of new concepts for theory, research, and practice. It both offers us a challenge and points us in new directions. The ideas

presented in this book provide a new lens with which to view professional counseling. This book will truly help us transition into the next millennium!

COURTLAND C. LEE
Professor of Counselor Education
University of Virginia
1997-98 President of the American Counseling Association

PROLOGUE

The certainty of change, coupled with the uncertainty of its impact on the profession of counseling, has led many to wonder about our future as professional counselors. As counselor educators, we routinely are questioned by students and practicing counselors regarding the future of our profession. Predominately, they want to know what our perceptions are regarding the impact of the economy, technology, policy initiatives, and social conditions on the profession, current and future projections of career options, and future directions for the profession of counseling in general. While reflecting on these questions, we believed that perhaps our students and practicing counselors were not unique in posing such questions and, in fact, suspected that numerous other professionals who provide counseling services in a variety of settings may be contemplating similar questions. It seemed most appropriate and timely to address the issue of future directions in the counseling profession, and thus, this book, *Professional Counseling: Transitioning into the Next Millennium,* was born.

In this book, we have attempted to forecast the future of professional counseling as it transitions into the next millennium. In initially preparing to write this book, we quickly realized that it could not be adequately written by one or two persons. Fittingly, the expertise of professional counselors, counselor educators, and scholars throughout the United States and abroad was enlisted in order to complete this task with the integrity this book deservedly commands. Some of the projections herein are supported by statistical and empirical data. However, many others are based on the knowledge, personal experience, intuitions, and gut feelings of highly respected professionals throughout the counseling community.

This book is designed to help professional counselors understand and prepare for future changes in the profession of counseling. Understanding the rationale and observable predictors of anticipated changes meaningfully facilitates and enriches the efficiency and effectiveness of professional counseling services, whether being provided by professional counselors or by other human service professionals who also provide counseling services (e.g., psychologists, social workers, etc.). Commensurately, this book is expected

to be considered a "must read" book for any human service professional who provides counseling services in the next millennium and is committed to continuing to champion professional counseling as a much needed and critical constituent of human compassion.

C.G.D. AND W.G.E.

ACKNOWLEDGMENTS

Any undertaking such as this unquestionably adds significant stress and pressure to the lives of many individuals, not just those of the editors. When we invited this book's 18 contributing authors to write chapters for us, none of them had the luxury of exchanging their writing activities with other responsibilities in their lives–their scholarly activities were *added* to their lives. For that, we are most appreciative. Without any doubt, the depth, breadth, and overall integrity of this book would not even near its prestigious essence if it were not for the individual and collective wisdom of our contributing authors. To each of them, we are truly indebted.

Likewise, our friends and colleagues in our university home, the Department of Rehabilitation and Mental Health Counseling at the University of South Florida, were uniquely supportive, helpful, and respectfully tolerant. A hearty "thank-you" is extended to three of our graduate assistants, Curt Mathes, Scott Rolston, and Laurie Slide, who offered genuine support, critical thinking, and proof-reading, and warm smiles while providing occasional unscheduled runs to the campus post office. We are convinced that our department's office manager, Ms. Shari Allen, was elated when we told her that the book was finished–in her typical style, Shari always was there for us and came through in the clutch. Our departmental colleagues, Joe, John, and Susan, also were supportive and very tolerant with our tardiness to meetings and staring out into space during in-the-hall chats.

Genuine respect and appreciation goes to Mrs. Marianne Bell, Word Processing Operator, Supervisor, whose technical and word processing brilliance literally "saved us" numerous times; moreover, her winning smile and warmth helped us through the tough deadlines. Our sincerest gratitude goes to Dr. Courtland Lee, immediate past-president of the American Counseling Association, for making time in his very busy schedule to read the book's manuscript and prepare the book's exceptionally insightful and very wise Foreword. "Thank-you," Courtland!

As was the case with our contributing authors, we also did not *find* time to write/edit this book, we *made* the time and *took the time* from elsewhere.

Frequently, we took time from our home lives–"Honey, how does this sentence sound to you..." and "Sweetheart, would you please read this for me..." recurrently rang through our homes. To our respective significant others, Charlie L. and Jenny V., we dedicate this book.

CHARLOTTE AND BILL

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PROFESSIONAL COUNSELING
Transitioning into the Next Millennium

Chapter 1

PROFESSIONAL COUNSELING: EVOLUTION, CURRENT STATUS, AND BEYOND

CAROLYN W. ROLLINS, JORGE GARCIA, AND MARSHANN THOMAS

Social and economic change impacts everyone. In every era, history has recorded challenges to individuals and institutions to accept and adjust to significant change. Counseling is a profession that helps individuals to understand and adapt to change (Blum, 1987). In the United States, counseling emerged as a response to needs of the people and the events of the times. This "responsiveness" continues to be a characteristic of the profession.

A major impetus for the evolution of professional counseling was a concern for mental health. Other contributing factors included the vocational guidance movement; the psychometric study of individual differences; the development of nonmedical, nonpsychoanalytic approaches to counseling and psychotherapy; and social change (Hayes & Aubrey, 1988). These factors, in the context of events in the nation's development, resulted in a favorable climate for counseling's development (Borow & Humes, 1987).

Industrial expansion in the late 19th and early 20th centuries altered the way in which goods were produced and marketed, as well, it changed the occupational structure of the workplace. Occupational inheritance decreased, and occupational competition increased. In addition, drastic demographic shifts were caused by rural-to-urban migration patterns and immigration. Many individuals found that as job demands changed, their skills became obsolete and their ability to compete diminished. Further, they lacked job-seeking skills. Moreover, the influence of social movements on the reform of social institutions also was a factor. For example, the perception of injustice spurred social movements based on beliefs in democracy and sociopo-

litical ideals of egalitarianism. The activists believed that individuals should be judged on their worth and should have an opportunity to develop to their fullest capacity. Their activism led to reforms that included child labor laws, women's suffrage, and other initiatives to increase literacy and provide short-term job training and placement. Another key factor was the expansion of vocational education programs. Initially, counseling took place in educational settings, focusing more on guidance than other forms of counseling (Brown & Strebalus, 1996). The National Defense Education Act (NDEA) of 1958 provided funding for school counseling programs and for the professional preparation of school counselors. Later, settings expanded to include colleges, veterans services, and vocational rehabilitation agencies.

Professionalization

Many significant developments occurred in the mid-1900s, primarily focused on theory building and professionalization. The theoretical foundations of the therapeutic approaches that are the basis for counseling practice today were developed. The theories underlying person-centered (Raskin & Rogers, 1995), rational emotive (Ellis, 1995), reality (Glasser & Wubbolding, 1995), and behavior(Wilson, 1995) therapies are illustrious of this period. During that same period, theories of career choice and career development were proposed by Ginzberg (Ginzberg, Ginsburg, Axelrod, & Herma, 1951), Super (Super, 1953), Roe (Roe, 1956), and Holland (Holland, 1966). Importantly, the work of these theorists provided professional counselors with alternatives to the medical model and the conceptual framework to expand beyond the group-focused vocational guidance and testing model.

Two primary influences on professionalization have been professional counseling organizations and credentialing. Professional organizations provide (1) information and resources for continuing education; (2) a means for association and interaction among professional peers, thus providing an avenue for professional activism; (3) advocating for continuous improvement and appropriate standards for ethical practice within the profession, and awareness; and (4) enlightened public policy outside the profession. The American Counseling Association (ACA) is the primary organization for professional coun-

selors, although affiliation with other professional organizations, such as the American Psychological Association (APA) and the American Association for Marriage and Family Therapy (AAMFT), are available.

Credentialing

Professional credentialing generally consists of one or more of three activities: (1) graduation from an accredited academic program, (2) certification, and (3) licensure. Each of these credentials requires that counselors demonstrate specific knowledge and skills for specific types of counseling services (Vacc & Loesch, 1994).

Most counselors are prepared in graduate programs in institutions of higher education. Through their relationship with institutions of higher education, counselor education programs are generally accredited by at least one accreditation body, a division of the Association of Colleges and Schools (ACS). Colleges and schools within higher education institutions may hold additional accreditations, such as the National Council for Accreditation of Teacher Education (NCATE). Thus, graduation from a program at an accredited college or university, in and of itself, provides a level of credentialing.

Although bodies like ACS and NCATE provide general accreditation, they do not specify criteria for the preparation of professional counselors. Thus, they do not provide strong credentials for counselors. The Council for the Accreditation of Counseling and Related Education Programs (CACREP), however, applies specifically to counselor education programs and provides a stronger credential. Students enrolled in, and graduates of, CACREP accredited programs are eligible for participation in the National Board for Certified Counselors' (NBCC) National Counselor Examination. Successful examinees are eligible for NBCC certification after completing their supervised internship. Certification therefore provides a second level credential.

Licensure is a legal process regulated by each state. Eligibility for licensure varies from state to state, but in most states, licensure requires an examination. In some states, a passing score on the examinations of the National Board for Certified Counselors (NBCC), the Commission on Rehabilitation Counselor Certification (CRCC), or

the Academy of Clinical Mental Health Counselors (ACMHC) is acceptable. Persons who obtain licensure are able to use the designation "Professional Counselor" or "Licensed Professional Counselor."

Professional counselors have made significant strides in the last two decades toward establishing professional counseling as a legitimate profession, separate and different from related professions such as clinical social work, clinical and counseling psychology, psychiatric nursing, and psychiatry. Professionalization activities have included gaining licensure in 43 states and the District of Columbia, achieving privileged communication for interactions between counselors and clients (American Counseling Association, 1997), and achieving societal recognition of counseling as an important component of mental health services (Sweeney, 1995).

Emerging Counseling Needs

Professional counselors assist individuals in coping with issues arising from the effects of expansion from national to world politics, the evolution of a global economy, and significant scientific and technologic advancement. These changes produced economic, technologic, and social conditions in the 20th century that altered the fiber of American society. Further, the impact of these social conditions is influenced by legislation. Consequently, the mental health needs of citizens will expand in the areas of life affected by the interaction of legislation with economic, technologic, and social conditions. This interaction will determine the nature of the issues with which Americans must cope and the nature of the evolution of the counseling profession.

Some of the challenges that will affect individuals' mental health needs and the profession of counseling can be predicted. First, the importance of understanding life-span development and age-appropriate tasks will increase as the age range of the population expands (Ronch, Van Ornum, & Stilwell, 1994). In 1996, life expectancy at birth in the United States was a record high of 76.1 years, while the infant mortality rate reached a record low of 7.3 deaths per 1000 live births (National Center for Health Statistics, 1996). The increasing frequency of counselors' involvement with decision making in situations ranging from (1) administering and interpreting tests and assessment

information; (2) disability; (3) treatment issues of children, adolescents, and adults; (4) family, marital, and relationship issues; (5) aging; to (6) death and dying, illustrate the importance of a lifespan developmental perspective.

Inclusion is a second area of concern. Our society is becoming more diverse, older, and poorer (Institute on Disability and Human Development, 1997). Projections suggest that by 2050, the population will be evenly divided between non-Hispanic whites and minorities, a trend sustained by higher birth rates among African Americans and Hispanics and immigration patterns (Ryan, 1995).

The American Association of Retired Persons (AARP) and the Administration on Aging (AoA) (1998) have predicted that the number of persons 65 years or older will more than double between 1997 and 2030. Among the 70 million elderly individuals, those who represent minority populations will increase from 15 percent in 1997 to 25 percent in 2030 (AARP-AoA, 1998). While aging, non-Hispanic whites will represent 79 percent of the increase, 238 percent of the increase will represent increases among older minorities, including Hispanics (368%), African Americans (134%), American Indians, Eskimos, and Aleuts (159%), and Asian Americans and Pacific Islanders (354%).

It has been suggested that the benefits of the record growth in the American economy and the lowest rate of unemployment in nearly 30 years have been inclusive of many American citizens (Clinton, 1999). Yet, despite the robustness of the American economy, many have not shared the wealth. *The 1998 Green Book* (Committee on Ways and Means) indicates that poverty has increased substantially. In 1996, more than 36 million Americans were poor. The rate of poverty, however, differs substantially for individuals in certain demographic subgroups, specifically individuals in female-headed households, children, African Americans, and Hispanics (Ways and Means Committee, 1998). As the United States moves closer to becoming a universalistic nation, awareness of the complexities of life in a multicultural society is essential for counseling effectiveness. While society struggles to define policy and enact processes for inclusion that are compatible with democratic principles, counselors must be cognizant of the fact that the circumstances and experiences of inclusion differ among different groups (Axelson, 1999).

Poverty is significant not only in its impact as resource deprivation, but also as a risk factor for increasing susceptibility to the effects of powerful economic and social forces that affect health and well-being. Ten million Americans, including almost four million children, do not get enough to eat (National Center for Health Statistics, 1998). About 4.5 million non-Hispanic whites, 2.4 million African Americans, and 2.4 million Mexican Americans do not get enough to eat. Although children and individuals who are poor are most at risk, over half of those who live with hunger live in families where at least one member is employed. For example, many low-income uninsured Americans may have to make a choice between paying for health care and paying for food. Further, Americans without health insurance are twice as likely to report being hungry as those who have health insurance. For many Americans, the experience of inclusion will be minimized by their lack of access to needed goods and services.

Health Care, Technology and Assistive Technology

Significant changes have occurred in the health care delivery system in the United States. Health care has changed from the traditional indemnity insurance model to a system of managed care. When employers were eliminating mental health and substance abuse programs, supporters believed that managed care saved these benefits (Thomas, 1998). Mental health costs have risen faster than general medical costs, and employers' savings associated with managed care have been pronounced. Reducing mental health costs has increased access for some poor persons, and managed care policies have promoted increased deinstitutionalization. However, numerous issues have arisen for consumers of health care services. Implementation of managed care policies has led consumers to raise questions about their right to choose health care providers, limitations on the types of services available under these insurance plans, and clarity with regard to who is eligible for which services and who can provide the services. Consumers' reactions have been so strong that legislators were prompted to introduce patients' bills of rights that would, if passed, have permitted consumer lawsuits against health maintenance organizations (Thomas, 1998).

At the same time, health maintenance organizations have alienated many professional counselors. Micromanagement practices have

threatened the client-therapist relationship, and reimbursement reductions have resulted in financial losses. Further, traditional approaches to therapy were challenged, but limited training opportunities were provided in approaches consistent with the managed care philosophy (Thomas, 1998).

Managed behavioral health care will continue to influence the shape of the health care delivery system. In 1996, mental health and substance abuse services were provided through a managed behavioral health care plan to over 100 million Americans with private health insurance (American Counseling Association [ACA], 1997). Federal legislation has escalated the enrollment of recipients of Medicare and Medicaid in managed care programs (AARP-AoA, 1998). In 1995, Medicare insured 33.1 million persons aged 65 and over and covered health and medical services received by four out of five (82.6%) of them (AARP-AoA, 1998). Managed care has become so pervasive that by 2000, only one in 10 employed persons will be covered by a traditional indemnity health plan (ACA), 1997). For counseling professionals, this suggests the importance of professional development on the one hand and promoting access to services on the other.

Access issues will be particularly significant for some individuals. Nearly 42 million Americans are uninsured, and millions of others are underinsured (President's Commission, 1998). Uninsured Americans include full-time workers and the spouses or children of such workers as well as retirees who no longer have employer-based coverage but are ineligible for Medicare. Several specific groups within the population, including those who are uninsured, poor, elderly, children, racial and ethnic minorities, and individuals who live with terminal illness, mental or physical disabilities, are especially vulnerable to health care problems and differential experiences in the health system (President's Commission, 1998). Individuals who are uninsured and underinsured (1) have less access to primary and preventive care, integrated social services, and continuity of care, and (2) are often at the greatest risk of receiving substandard care that is inadequate to meet their needs.

Technology and Ethics

Technological advances in medicine mean that individuals will increasingly confront the need to make life-sustaining decisions for

themselves and their loved ones. At the same time, escalating numbers of people will be able to make life-creating decisions. Counselors will increasingly be consulted by couples exploring their family options (Tangri & Kahn, 1993). As biomedical advances continue, counselors will be needed to assist with decision making and resolving issues in such areas as organ transplantation, genetic testing, and artificial reproduction. Furthermore, issues associated with the right to life and the right to die will continue to be troublesome for some individuals and their families, as well as the greater society.

Advances in biomedical technology have impacted the work of professional counselors. Counselors who are competent will have attained knowledge about the procedures involved, will understand the implications, and will respect the principle of client autonomy. Dilemmas involving competence, confidentiality and informed consent, and client welfare will present challenges to ethical practice. Moreover, counselors serving individuals and families experiencing medical challenges will confront questions involving who should receive such treatment and who should make the decision, while attempting to help them make these kinds of determinations. The principle of autonomy may conflict with other principles such as beneficence, nonmaleficence, or justice, especially because other parties may be involved besides parents and children, such as insurance companies, government, courts, and others who need or desire the same benefit. Counselors working in medical or family settings dealing with these issues need to be particularly knowledgeable about specific medical procedures and have the competence to understand and interpret ethical principles.

Counselors may be asked to provide screening procedures that assess psychological factors, such as personality disorders, mental illness, past disorders, suicide potential, depression, and chemical dependence, that influence the outcomes (Freeman, Westpal, Davis, & Libb, 1995). Counselor competence is critical because these assessments are key factors in the decision of who receives and, conversely, who does not receive, treatment that may save a life.

CONCLUDING COMMENTS

The challenge to individuals and institutions to accept and adjust to significant changes, will continue into, and likely beyond, the new millennium. Professions, too, must adapt to respond effectively to a changing environment. The next millennium will bring challenges to professional counselors to adapt practice strategies to the demands of the managed behavioral health care system while retaining the sensitivity to human needs that has been such a fundamental influence in the development of the profession. Further professional activism will be needed to confront the issues of access and inclusion that may serve as barriers to the most vulnerable segments of the population receiving timely and appropriate services. The challenge to engaging in ethical professional behavior will be greater than ever before. Biomedical advances and the struggle to balance accountability measures in a managed health care environment will feature prominently in the ethical struggles of the next millennium.

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Chapter 2

MANAGED CARE AND PRIVATIZATION IN COUNSELING AND REHABILITATION

REGINALD J. ALSTON AND DEBRA A. HARLEY

Health care in the United States always has been of major concern to care professionals and in recent years has become a primary concern to most people (Alston, 1997; Frank & VandenBos, 1994). In 1996, the Institute of Medicine (IOM) called for collaboration between public agencies and managed care organizations to jointly provide for the infrastructure and delivery of health care services to customers (Tannenbaum, 1998). Health care planning seems to be at a turning point and signs of change emanate from several avenues. First, there is an increased rate in the development of linkages, alliances, and multi-system networks forming nationally. The trend of consolidation is one of the parameters upon which policy makers and health care visionaries base strategic planning (Duchene, 1994). Medical rehabilitation is market driven, resulting in specialized programs of service delivery that have cost-effective outcomes (Carrillo, 1993); this marks the second sign of change of health care planning. Third, health care reform debate at multiple levels of government and states' delivery and financing of health care services, within the context of a balanced budget, have moved the influence of the Medicaid system to the forefront as fundamental in state health care reform initiatives (Frank, Sullivan, & DeLeon, 1994). Finally, disability policy, either of an ameliorative or a corrective nature, will continue to be a significant influence in the determination of whose stake is more important in priority of services (Schriner, 1990). Standardization of treatment and health care availability, accessibility, and quality are at the core of health care management and reform (Alston, 1997; Tannenbaum, 1998). Collaboration between the public and private sectors in the delivery

of health care and rehabilitation services is predicated on a nonadversarial philosophy. It is not designed to be a conflicting and counterproductive function.

Health care reform reflects a shift in the fundamental relationship between consumers and providers, with this shift having a profound effect in the private and public sectors of service delivery. The magnitude of change in health care policy has been swift, extensive, radical, and unprecedented, reshaping the landscape of medicine and the allied professions in the delivery of services for consumers with and without disabilities (Alston, 1997). The solutions to the continuing dilemma of adequate and affordable health care for consumers include attempts to privatize public services, the downsizing or streamlining of government intervention and regulation, decreased lengths of stay in hospitals (Blades & Harley, 1997; Dinwoodie, 1991; Hagalund & Frank, 1996), reductions in the use of individual treatment, and an increase in more generic programming (Duchene, 1994). In addition, employers have addressed the escalation in health care cost by reducing coverage and/or offering benefits packages such as managed care (e.g., health maintenance organization [HMO], preferred provider organizations [PPO], and independent practice associations [IPA]) (Alston, 1997). As professionals and society prepare to move forward into the next century, attention must be given to resolution of the health care dilemma.

The purpose of this chapter is to provide a review and synthesis of: (1) the implications of managed care and privatization, (2) managed care for individuals with disabilities, (3) requirements related to managed care plans, (4) historical precedents of current privatization and managed care practices, and (5) cost control issues. The chapter will not be inclusive about these issues; rather, it is intended to serve as a resource and facilitate further inquiry and opportunity for health care planning.

MANAGED CARE PRIVATIZATION

Managed care is a formalized approach to medical service provision in which the financing and delivery of care is established through contracts with predetermined/preselected physicians and hospitals

who deliver comprehensive services to enrolled members (Cornelius, 1994; Hunt & Growick, 1997). The core concepts of managed care are cost containment, control of utilization, and limited information dissemination (*A Guide to Managed Care, 1997;* Alston, 1997). Most managed care plans assign their enrollees to a primary care physician who is responsible for coordinating consumer care and granting referrals to specialists. The most common form of managed care plans is an HMO that provide specific health services for a fixed premium. Other examples of managed care plans include PPO's that refer consumers to specific doctors and hospitals in which enrollees receive services at a discount, and point of service (POS) in which consumers are assigned to a primary care physician in the network. Both PPO and POS allow consumers to pay an additional fee to see physicians outside of the network (*A Guide to Managed Care, 1997*). Because of the requirement of consumers to receive any and all subsequent referrals from the primary care physician, managed care is generally referred to as the "gatekeeper" function (Hunt & Growick, 1997).

Privatization is the provision of publicly-funded services by nongovernmental entities. In practice, privatization includes a broad range of modalities such as voucher programs, contracting out for services, and the sale of public assets to the private sector (Nightingale & Pindus, 1998). Private sector refers to both for-profit and nonprofit organizations (Dinwoodie, 1991). Relatively unchanged over the last 60 years, one dramatic new strategy of privatization initiatives involves contracting for the administration of entire public-funded systems in the social and human services (e.g., welfare, child support, workforce development) (Nightingale & Pindus, 1998).

Advantages and Disadvantages

Both managed care and privatization have advantages as well as negative consequences for individual customers and social and human service organizations. Advantages for recipients include: (a) lower out of pocket expenses, (b) less paperwork, (c) more comprehensive benefits including some prescription drug coverage, (d) a focus on prevention, (e) a continuity of care (*A Guide to Managed Care, 1997*), (f) increased flexibility, (g) reduced cost, (h) increased ability to provide locally-based services, (i) avoidance of duplication, (j) ability to pro-

vide specialized services, (k) improvement in consumer and advocate relations, and (l) decreased need for permanent staff (Dinwoodie, 1991).

For each advantage there is a negative consequence or a philosophical contradiction. Managed care and privatization present somewhat different disadvantages; therefore, they will be illuminated separately. Major disadvantages identified for managed care are as follows: (1) a consumer is unable to continue seeing one's current physician if he or she is not part of the managed care plan selected; (2) one may have more limited access to specialists since the primary care provider must authorize all visits, and subsequently, may have financial incentives to reduce some services for the managed care group of which you are a member; (3) most managed care plans have little or no experience with certain disabling conditions and consequently may be less likely to detect or handle certain medical complications properly; (4) some plans have a shortage of specialists resulting in a long waiting period for and between appointments; (5) with the exception of certain conditions, one does not get to choose a specialist as their primary care physician; and (6) most, if not all, managed care plans limit the amount of visits each year (*A Guide to Managed Care, 1997*).

Similarly, privatization is accompanied by a series of disadvantages: (a) lack of control; (b) services are too expensive; (c) a lack of available contractors, especially in rural areas; (d) fragmented service delivery; (e) a tendency to promote special interest groups; and (f) an erosion of the public rehabilitation component (Dinwoodie, 1991). In addition, privatization is likened to streamlining and possesses inconsistencies and flaws in the processing of organizational activities. The most salient are as follows. First, the process may become more efficient, but not necessarily more effective. Second, the process may have little or no effect on other important variables which are known to influence outcomes (Stephens, 1997). Third, given the priority of services to consumers with the most severe disabilities, as well as the cost and length of such services, (Alston, 1997; Hunt & Growick, 1997), privatization may be cost prohibitive.

In their examination of the privatization of public-based social and human services, Nightingale and Pindus (1998) take the position that privatization is not inherently positive or negative; instead, they contend that performance or effectiveness depends on implementation.

Given the fact that public, private, and nonprofit sectors each have strengths and weaknesses, accountability for outcomes is the key factor in rehabilitation and health care (Blades & Harley, 1997; Nightingale & Pindus, 1998). Both managed care and privatization entail risk factors. promote competition, and offer alternative options for health care and rehabilitation services. The intersection between public health, managed care, and privatization simultaneously calls for cautious scrutiny and deliberate action.

MANAGED CARE FOR INDIVIDUALS WITH DISABILITIES

Two decades ago, Verville (1979) summarized the predicament of consumers with disabilities as *dismal in care* and l*acking purposefulness in policy*. Specifically, "care for those with chronic illness and disability is still a stepchild in the health and social service systems despite improved efforts of late" (p. 49). Similarly, Alston, Bell, and Leung (1997) echoed the same sentiment with regard to federal legislation designed to provide equitable services. That is, although the Americans with Disabilities Act (ADA) appears to be comprehensive as civil rights legislation, in regard to issues of health care coverage, it is restricted to employment settings in terms of health benefit plans offered as part of employment.

While it is beyond the scope of this chapter to provide an in-depth discussion of the impact of managed care for all disability groups, select disabilities are discussed to illustrate such impact on service delivery and outcomes. As a result of managed care, for example, persons with spinal cord injury (SCI) have experienced adverse changes in: (a) acute care, (b) short- and long-term outcomes in functional status and community integration, (c) rehabilitation care (e.g., inpatient-acute, sub-acute, day hospital, and outpatient), (d) home care, and (e) readmission for complications (National Institute on Disability and Rehabilitation Research, 1998). An assessment of managed care on these phenomena may offer differential outcomes from those of more traditional health insurance in terms of services received (i.e., providers, services, and durations). While some customers with severe disabilities require a comprehensive benefits package, managed care packages are mostly based on an acute care model (Hunt & Growick.

1997). This approach is nonadvantageous to individuals with spinal cord injury. Segedy (1996) reported that discharge for customers with paraplegia, which usually occurred after about three months, is now occurring after 30 days, and for those with quadriplegia, the customary discharge after six months has been curtailed to two months.

Persons who have incurred traumatic brain injury (TBI) also do not fare well in the managed care organizations (MCO's). Hagen (1998) pointed out that MCO's, like the fee-for-service system, does not take into account either the types of services, including physical and occupational therapy, or the long-range needs of those with TBI. In order for consumers with TBI to benefit from MCO's, they must contract with health care systems that can provide the full spectrum of care for a single capitated price. Hagen acknowledges that MCO's are moving in this direction and away from traditional segmented systems of rehabilitation. However, in order to maximize benefits to customers with TBI, providers must take a "life care planning" approach to rehabilitation in which the following question must be addressed: "We have a limited amount of money with which to meet the needs of our clients for the rest of his or her life; how can we best use it to produce and sustain his or her quality of life?" (Hagen, 1998, p. 3). In order to adequately and appropriately manage a consumer's money, the provider must, when appropriate, completely change the pattern of rehabilitation service delivery to be clinically and fiscally feasible (Hagen, 1998). In essence, the provider will need to align the type and timing of services with the prevailing and long-term needs of the consumer across the entire continuum of rehabilitation (Hagen, 1998; Nightingale & Pindus, 1998).

The movement toward primary care in medicine and an increase in the use of physician extenders (e.g., advanced practice nurses and physician assistants) is likely to occur in the mental health area, with greater use of master's level providers of all types (Frank & VandenBos, 1994). Psychological services are largely ignored in most states' health reform programs because they are viewed as having minimal impact on cost and access. Some states offer extensive coverage for psychological services, whereas others provide bare-bone coverage (Frank, Sullivan & DeLeon, 1994). For example, the state of Maryland requires small businesses (50 or fewer employees) which offer health insurance to provide a standard plan in the area of mental health and

substance abuse on parity with physical illness (Heath, 1994; Hughes, 1993). The state of Washington's legislation mandates case managed mental health and chemical dependency to the extent that such services reduce inappropriate utilization of more intensive or less efficacious medical services (S. 5304, 1993). However, the language in the plan is generic and limiting and gives the Panel of the Health Services Commission discretion in defining benefits (Frank, Sullivan & DeLeon, 1994). Many states use managed care mechanisms to contain cost of psychological services (Sullivan, 1993).

Managed care has been expanding to include coverage for children and adolescents with chronic illnesses and disabilities who have previously received health care services through a combination of fee-for-service plans and public programs (e.g., Medicaid, Aid to families with Dependent Children). However, many managed care plans are not designed to be responsive to the needs of children with special medical/habilitative needs (Ziring, Brazdiunas, Cooley, & Kastner, 1998). Ziring et al. (1998) suggest that the major advantage of managed care for children and their families is improved access and coordination of services. Children with disabilities differ from adults with disabilities in managed care environments in several ways. One, the needs of children are affected by the changing dynamics of different developmental stages. Two, the epidemiology and prevalence of childhood disabilities, with many rare and low incidence conditions and few common ones differ greatly from that of adults in which the converse is true. Three, as a result of children's needs for adult/parental protection and guidance, their health and development depend significantly on their families' health and socioeconomic status (Jameson & Wehr, 1993). According to Lewit and Monheit (1992), an estimated 5 percent of children with special health care needs account for more than 35 percent of health care costs of all children and adolescents. In addition, these children have more complexed disabilities (e.g., multiple, life-long, and/or technology-dependent) that compound their needs.

Managed care poses other risks for children with chronic illness and disabilities. First "risk avoidance" has resulted in the exclusion of high-risk populations from many managed care initiatives. Also, many state Medicaid programs have continued the fee-for-service arrangement among high-risk populations. Second, "carve out" strategies

exclude persons based on risk or their need for ancillary services, and capitated programs create disincentives for primary care pediatricians to take on high-cost patients (Halfon, Inkelas, Wood & Schuster, 1996). Third, the absence of clear standards of care and clinical guidelines, especially in reference to rare conditions for which there is a lack of consensus on what constitutes appropriate home or community care, makes it difficult for pediatricians to advocate for appropriate services. Fourth, changing technologies and a paucity of outcome data concerning habilitation and mental health services result in arbitrary caps on services provided by managed care companies (Cartland & Yudkowsky, 1992). Finally, partially or fully capitated reimbursement strategies create disincentives for appropriate subspeciality referral (Ziring et al., 1998).

REQUIREMENTS RELATED TO MANAGED CARE PLANS

The American Academy of Family Physicians (AAFP) (1998) (1) has developed requirements related to managed care plans, and (2) outlined programs and point of service plans in order to facilitate physicians' interaction with managed care plans. The intended use of these requirements is to assist all parties involved to provide high quality, cost-effective health care to enrolled populations (AAFP, 1998). The Academy offers the following programs and point of service plans as a "living document" that will be modified in accordance with new evolutions and changes in the health care market.

Programs and Point of Service Plans

The requirements are designed to build bridges, not to erect barriers, between family physicians and managed care organizations.

1. Managed care plans should provide sufficient information about plan terms and conditions to allow prospective enrollees and patients to make informed enrollment decisions.
2. Physicians must be able to discuss any information, clinical or financial, necessary for their patients to make informed decisions regarding their medical care.

3. Managed care plans should demonstrate that they can provide sufficient access to physicians and other providers so that all covered medical services are provided in a timely fashion.
4. Managed care plans should develop contracting criteria for physicians; such criteria should be available for review by physicians and should be utilized in determining physician selection, retention, and disenrollment.
5. Managed care plans should have sufficient financial reserves to ensure proper and timely payment for covered services.
6. Managed care plans should establish a mechanism by which physicians enrolled with the plan can provide input into the plan's medical policies.
7. Managed care plans should periodically provide to each physician data to evaluate his or her performance relative to stated plan performance criteria and in relation to a comparable group of plan physicians which are age, sex, and severity adjusted.
8. In regard to physician disenrollment, managed care plans must provide physicians with the reason for disenrollment, the right to appeal the disenrollment decision and sufficient notice of disenrollment to allow the orderly transfer of patient care responsibilities.
9. Medical directors of utilization review programs should make coverage decisions based on clinically sound guidelines; however, physicians should have the right to appeal adverse coverage decisions and have such decisions reviewed by another physician with the same expertise and of the same specialty.
10. Utilization review programs must respond to requests for authorization of a service within two business days.
11. Whenever practical, potential enrollees should have a choice of health plan at least one of which should include a point-of-service option.
12. Managed care plans may impose an additional, actuarially justified premium and higher patient cost-sharing requirement for "out-of-network" care.
13. Economic or capacity profiling of a physician must be adjusted to recognize case mix, severity of illness, age of patient, and other features of a physician's practice that may account for higher than, or lower than, expected costs.

14. Managed care plans should not discriminate against individuals with expensive, long-term, or chronic medical conditions by excluding such patients (i.e., preexisting conditions).
15. Managed care plans should not discriminate against vulnerable, high-risk patient populations via the exclusion of physicians whose practices contain substantial numbers of such patients.
16. Managed care plans should not utilize any criterion that excludes a physician based on sex, race, creed, national origin, or any other factor prohibited by law (AAFP, 1998).

In order for managed care organizations to demonstrate the capacity and the ability to serve enrollees, physicians must be held to standards of conduct and service quality that are equal to those provided for customers without severe disabilities. By exercising the above stated points, some aspects of managed care organizations can be improved. In essence, the provider (not the managed care/payor per se) must deviate from the standard approach and conceptualize a completely different continuum of rehabilitation and medical intervention as well as ways of utilizing resources across that continuum (Hagen, 1998).

Workers' Compensation

Workers' compensation managed care plans provide tor the delivery and management of medical treatment for injured employees through a network of health care providers (Minnesota Department of Labor and Industry, 1995). Employees select a treating doctor from the network of physicians which include generalists and specialists. Managed care plan case managers, who are licensed health care professionals, monitor and coordinate the delivery of quality medical treatment. The managed care plan must also include a process for resolving disputes (Minnesota Department of Labor and Industry, 1998).

While the workers' compensation program never abandoned the concept of providing rehabilitation services to help workers back to work, insurers faced with increasing costs have used private sector rehabilitation providers in selected workers' compensation cases (Berkowitz, 1990). Given the latitude and discretion of individual

states to regulate workers' compensation, any changes in compensation levels or eligibility rules which affect the incentive structures would be influenced by demand. States tend to be compelled to employ rehabilitation services for injured workers because some legislators view rehabilitation as an entitlement in much the same way that they are entitled to medical care to diminish the effects of their injury (Berkowitz, 1990). The private sector is the primary provider of services; however, states may certify rehabilitation providers and workers may select from the list of certified providers.

Medicaid

The Medicaid program is the primary federal program providing health care funds to low-income families, the elderly, and people with disabilities. In addition, home health users are commonly eligible for Medicaid if they required more than 200 home visits (Mauser & Miller, 1994). In a study of Medicaid policies and home health care provisions for persons with disabilities, Buchanan and Alston (1997) examined each state's Medicaid policies that define reimbursement, utilization, and coverage of the home health care needs of persons with disabilities. The results indicate that state Medicaid programs paid for a range of services, including skilled nursing care, physical, speech and occupational therapies, home health aid services, medical social services, medical supplies, and outpatient services. In addition, there was wide variation among states in payment levels, ranging from $27 per visit to $180 per visit, with the average Medicaid payment for skilled nursing care being $68 per visit. Other findings indicate utilization limits on home health aids, restricted payment for live-in attendants, and seldom paid reimbursement for specialized home and community-based care services covered under the Medicaid waiver program.

Generally, requirements related to managed care plans vary depending on the state's specifications and regulations. Programs and point of service plans strive to include minimum standard that can be applied consistently across the board. However, public and private sector service providers differ on several critical aspects: (a) the goals of rehabilitation, (b) when to intervene, (c) how to select persons for services, (d) what services are to be offered, (e) who should be autho-

rized to offer such services, and (f) who should pay for such services (Berkowitz, 1990).

HISTORICAL PRECEDENTS OF PRIVATIZATION AND MANAGED CARE PRACTICES

Managed care is a relatively new concept (Hunt & Growick, 1997) guided by the HMO Act of 1973 in which customers relinquished their right to choose their doctors in return for a promise of lower premiums (Keigher 1995). The current health care controversy is rooted in a history of "national ambivalence regarding the provision of health care" in which the American health care system is predicated on an unstable compromise between two seemingly contradictory concepts (Frank & VandenBos, 1994, p. 852). First, these two concepts include rugged individualism, which asserts that individuals take care of themselves (including paying for health care) and thus, that health care should be provided through a market-driven approach. The second inclusion is the concept that Americans are generous and compassionate, taking care of individuals who are unable to provide for themselves (Stevens, 1989). Frank and VandenBos (1994) indicated that the ambivalence over these concepts has resulted in a highly decentralized national health care system.

In times of expansion and during contraction of government services, these have been major watershed points in the history of social policy (e.g., the Progressive Era in the late 19th century, New Deal, Great Society, and Reagan years). In modern history, employers did not provide health insurance until shortly after World War II. Since the mid-1950s, health insurance coverage has been an employer-provided (and untaxed) part of workers' compensation (Frank & VandenBos, 1994). Chronologically, national health care reform has unfolded to include the following:

1. In the late 1940s, Harry Truman supported efforts to build a national network of hospitals, expand the supply and level of training of health practitioners, and increase federal funding of health research.
2. In the 1960s, Lyndon Johnson led the debate on increasing access for the elderly and disabled in his successful efforts to create the Medicare and Medicaid programs.

3. In the 1970s, Richard Nixon, responding to growing concerns about the increasing numbers of uninsured American workers, proposed legislation to create a national insurance system which would have mandated that all employers pay for a portion of a comprehensive benefits package for all employees.

4. Over the next 15 years, health reform surfaced briefly during the Carter and Reagan administration, and Congress enacted reforms, including the prospective payment system for hospitals and the Resource Based Relative Value system (RBRVS) for physician payment (Frank & VandenBos, 1994, p. 853).

5. In the 1990s, Bill Clinton forwarded his health reform plan, the Health Security Act to Congress. The legislation, as introduced (S. 1757/H.R. 3600, 1993), proposed sweeping reforms in the U.S. health care system. Although the original proposal was disregarded, it served as a catalyst for reform of the purchasing and delivery of health services. The proposed legislation would have guaranteed all Americans comprehensive health benefits and transformed the purchasing and delivery of health care (Frank, Sullivan, & DeLeon, 1994, p. 856).

The draft of President Clinton's bill included reforms of the purchasing and delivery system, insurance premium rating methods, and health workforce and the establishment of a National Health Board with the authority to monitor and regulate health care spending. State health reform legislation has incorporated many aspects of the Clinton bill (Frank, Sullivan & DeLeon, 1994).

The trend in managed care and disability policy will continue toward privatization and be influenced by payment capitation, primary care physicians use of physician extenders, and civil rights orientation (Alston, 1997; Frank & VandenBos, 1994; Schriner, 1990). Any effort to transform disability policy and managed care will require dialogue with political scientists, policy analysts, and financial analysts (International Finance Corporation 1995; Schriner, 1990). According to the International Finance Corporation (IFC), key principles that guide successful privatization programs include (1) balancing political and economic objectives, (2) using flexibility in designing privatization programs, and (3) maximizing transparency, which is crucial to securing popular support for the process. In addition, the IFC reports that privatization is overwhelmingly positive because it delivers benefits for national economics, privatized firms, and customers. Furthermore,

once initial privatizations are carried out, it becomes easier for governments to build a political consensus for further reform.

Historically, cost reduction has been accepted as the primary reason for privatization of state and local government activities (Dinwoodie, 1991; Mercer, 1983). In order to understand why this shift toward privatization has occurred, Dinwoodie conducted a survey that yielded responses which he clustered into three categories: financial, governmental, and strategic. When economic times are difficult and governmental pressure requires agencies to do more with less, agencies then have opportunities to make the kinds of choices that nongovernmental-dependent business are free to make (Dinwoodie, 1991).

The extent to which privatization is being utilized by the public sector continues to increase. In recent years several federal initiatives have encouraged more privatization: welfare reform, one-stop career centers, and child support enforcement (Nightingale & Pindus, 1998). Similarly, Medicare and Medicaid are increasingly being administered through private managed care plans. "Proponents of the trend insist that managed care can remedy the fragmented and costly service delivery system of public assistance by instituting greater controls and coordinated service systems" (Alston, 1997, p. 8). Any change in trend, positive or negative, will produce substantial impact for consumers in rehabilitation and other human service agencies.

COST CONTROL AND MODELS OF PRIVATIZATION

Cost control mechanisms have employed an array of approaches, ranging from market-driven models to more regulatory methods (Frank, Sullivan & DeLeon, 1994) in an effort to control escalating health costs. Market-driven approaches have been used in the Jackson Hole model which proposes better cost control by increasing the effectiveness of purchases through the use of Health Insurance Purchasing Cooperatives (HIPCs) or alliances that offer customers choices based on standardized benefits packages, as well as information on the cost and quality of services (Bingaman, Frank, & Billy, 1993). The components of the Jackson Hole model include efficient delivery, high-quality services, and an effective primary care system (Frank, Sullivan & DeLeon. 1994).

The most prevalent regulatory method is the single-payer system or all-payer system to regulate health care costs (Frank, Sullivan, & DeLeon, 1994). In general, the all-payer system prohibits hospitals from offering discounts except for small discounts for prompt payment. This all-payer system was first introduced in Maryland in 1976 (Anderson, Chaulk, & Fowler, 1993). The regulatory method has been effective in controlling health care costs.

Medical rehabilitation has experienced substantial growth in the last decade. Medical rehabilitation is market-driven, resulting in specialized programs (Carrillo, 1993). Market-driven approaches are readily seen in acute care. Mahoney (1995) indicated that "the rehabilitation patient with medical complexity adds a new dimension to traditional interdisciplinary issues in rehabilitation" because "patients are transferred 'quicker and sicker' to rehabilitation programs" to facilitate "health care reform, prospective payments, functional related groups, capitation, and managed care" (p. 152). Another trend in acute care is that consumers are leaving acute care and transitioning into long-term care settings without emphasis on outcome accountability (Duchene, 1995).

An examination of privatization involves looking at two separate but related dimensions, market competition and sectoral roles (Nightingale & Pindus, 1998). Market competition ranges from open competition for all public services to government contracting for specific services. Sectoral roles include government oversight of private services versus separate systems of services operated by government, for-profit and/or nonprofit entities, versus public-private partnerships (Nightingale & Pindus, 1998). In market competition, public agencies would have to complete against each other as well as nonprofit and for-profit service providers. Conversely, sectoral roles are related to activities or functions performed by the governmental and nongovernmental sectors, regardless of whether funds are exchanged or if there is a formal agreement (Nightingale & Pindus, 1998).

CONCLUDING COMMENTS

Managed care and privatization have become mainstays in health care and service delivery. Both offer advantages and disadvantages to

consumers. Privatization will continue to challenge public sector service providers to face the reality that the issue is not so much public versus private, but monopoly versus competition. One also must be cognizant of the risk involved in privatization. Effectiveness of any program plan or delivery approach depends on the implementation of the agreement process, the agreement itself, performance criteria, and monitoring processes.

Service providers must be aware and informed about the trends in health care. Recognition of the standardization of treatment and health care availability are crucial because of their impact on decision-making. In essence, knowledge must be extended beyond content specialization to include an understanding of the interplay between political, policy, and financial strategies. Managed care and privatization definitely have direct implications for individuals with disabilities, children with special needs, and low-income individuals. Advocacy for appropriate health care for these individuals is paramount.

In the final analysis, service providers in the public sector must be able to bridge effectiveness with efficiency, productivity with competition, and growth with quality if consumers are to be the true beneficiaries of services. A functional mix of affordable and effective health care strategies is required, and privatization is one possible component of the overall approach. Rehabilitation and other human service providers are confronted with both a challenge and an opportunity for advancing quality service provision. In part, this chapter offers some direction in this effort, and in part, it raises the question what is the next direction or trend for public sector human service providers'?

As we matriculate into the next millennium, several megatrends are forecasted for private practices and managed care. This chapter's analysis of future implications for professional counselors utilize the influence of existing trends as the gateway to the 21st century. Clearly, the trend toward privatization will continue. Several issues will impact counselors and other human service providers as part of this trend. First, the issue of accountability will continue to be of primary concern. Once service delivery is the domain of the private sector, the counselor needs to determine ways to insure that the consumer is receiving adequate and appropriate services in a timely manner. The counselor will need to consider if he or she is to intervene and under what circumstances. The boundary of the counselor's authority

becomes ambiguous and uncertain as a result of privatization. The implication for counselors would be to rethink their roles and functions. Second, privatization has ushered in case management services throughout the rehabilitation and insurance industries, which will continue to increase in the future. Counselors will find themselves in the role of case manager that should facilitate the consumer's progression through the various phases of rehabilitation. The case manager/counselor in actuality becomes a liaison between the public and private sectors, while functioning as a member of the rehabilitation team. However, the counselor's authority remains ambiguous.

A third megatrend of privatization is from central government to individual empowerment. The hope is that the transformation will focus on individual needs rather than on classes of persons. Although this is not a new concept in human service agencies, this trend will increase in the future. Counselors will continue to play a vital role in the empowerment movement as advocates and change agents, especially for consumers who are unaware of intervention and service alternatives. Clearly, counselors will facilitate consumer choice in both public and private sectors.

Privatization and the contracting out of public services will cause a shrinkage in the number of counselors working in the public sector. The implication for counselors includes possible employment in the private sector, but with a reduction in employee benefits (Nightingale & Pindus, 1998). In addition, counselors may consider employment as consultants. Another implication for counselors is a redefining of criteria for professionalism (i.e., licensure and certification). The definition of professionalism will continue to be linked to training and curriculum issues. This is the fourth megatrend with serious implications for counselors.

Finally, for professional counselors and other human service providers working with consumers with disabilities, knowledge of managed care systems and privatization with respect to the unique needs of the specific populations they serve becomes paramount. In many ways the counselor's traditional roles (i.e., service coordinator, advocate, and counselor) will continue, but their areas of expertise will expand. For example, instead of working with a specific disability group or a general caseload, the counselor will need to possess expertise in family counseling, career and employment counseling, medical

services, and life planning skills. All of these skills will serve to either supplement or replace functions normally assumed by managed care and private sector providers. If this proves to be cost effective and efficient, the public sector will remain as a large part of service delivery. Failure of the public sector to exhibit these characteristics will result in the private sector becoming the primary provider of services.

In conclusion, both the public and private sectors will continue to have a presence in service delivery for rehabilitation and other human service agencies. Implementation of strategies will determine effectiveness and efficiency of both sectors. While these two sectors are often viewed as competitors, they can be complementary. In essence, neither of the two will replace the other; however, one may dominate the other based on the social, economic, and political whims of the times. In 1979, Verville stressed that "care for those with chronic illness and disability is still a stepchild in the health and social service system despite improved efforts of late" (p. 49). Twenty years later, this statement is extremely relevant and true. Unfortunately, managed care and the trend toward privatization will do little to alter this projection in the future. We must be cautious to not let the new millennium simply be a repeat of history. Essentially, managed care and privatization "potentially rewards underservice" (Hoffman, Rice, & Sung, 1996, p. 1474). In the managed care and privatization systems, counselors are likely to have to deal with consumers in a more selective and restrictive manner to fit within the atmosphere of payment capitation that these systems strive to preserve.

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Chapter 3

SPECIAL TECHNOLOGY FOR THE NEXT MILLENNIUM

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To begin to appreciate the role of technology for the next millennium it is necessary to understand how professional rehabilitation counseling has evolved through most of the last century in our country. This unique and special kind of counseling provides insight into the future of professional counseling as more and more types and styles of generic professional counseling come to the experience, knowledge, and wisdom revealed by the cutting edge professionals in rehabilitation counseling. This field, with its subsidiary relationship with rehabilitation engineering, has moved from the wooden wheelchair of Franklin D. Roosevelt to the electric and electronic marvels available today in wheelchairs, adapted cars and vans, public busses, and even aircraft and boats which are "handicapped accessible." Perhaps even more breathtaking are the new technologies which allow one to virtually wear a personal computer. "The way computers are shrinking these may well be the last PC you can actually see....20 years from now you won't even think about computers. They'll be hidden within everything you use" (Ditlea, 1998, p. 59). The impact of special technology "is likely to be mind-bogglingly profound and complex" (Leslie, 1998, p. 37) and expand assistive technology resources not just to those with disabilities and older adults but to all people. Because counseling in rehabilitation begins with basic and generic, and then continues on to the unique and special concerns of rehabilitation, and because so much of the future of rehabilitation in the next millennium will be involved with computers and technology, this speciality area provides a unique forum from which to view the transition into the new millennium for special technology and its future relationship with professional counseling.

While rehabilitation counseling is generally considered to have an established legal and legislative beginning within this century (Tucker, 1994), the history of rehabilitation extends much farther back in time as it relates to the importance of work itself and its role in primitive societies (Matkin, 1985b). Subsequently, more organized and ordered rehabilitation efforts in the Greek and Roman eras, and pre- and post-Civil War times in the United States, provided parameters by which to view technology, work, and the role of workers with disabilities within the tenor the time (Rubin & Roessler, 1995).

As noted in Chapter 1, the socio-cultural-political-economic climate of the environment often dictated the importance of work and the underlying considerations upon which rehabilitation counseling was based. In much the same way, the technology of the times played an equally important role in how rehabilitation would affect the lives of people with disabilities. Manual tools and individual work, to machines and group work, to the Industrial Revolution and teams of workers, to the advent of the printing press, typewriters, and finally computers and computer-assisted work have in some ways lead us back to the individual worker and their individual tools.

By understanding our history, from whence we have come, we can begin to more accurately view our current status and how we may transition into the next millennium. Heppner et al.(1995) tell us that our history prepares us to (1) prepare to plan for the future, (2) instill a sense of identity with the profession, and (3) increase the problem-solving competency of current and future rehabilitation counselors. It is the professional rehabilitation counselors of today and tomorrow who must therefore "be prepared to assist individuals with disabilities in adapting to the environment, assist environments in accommodating the needs of the individual, and work toward full participation of individuals with disabilities in all aspects of society, especially in work" (Szymanski, 1985, p.3). If history tells us anything, it is that our evolution has greatly expanded an increasingly extensive array of services to an ever increasing population of persons with a wide range of physical and mental disabilities (Leahy & Szymanski, 1995). Surely rehabilitation counselors working on violence issues (Barrett et al., 1997b & c), in school systems (Trolley, 1996), and as expert or fact witness in court testimony for a variety of types of litigation (Granello, & Witmer, 1998; La Forge & Henderson, 1990) were not seen as viable employment trends just a decade or two ago.

The new millennium will begin with two major emphases areas within which advanced technology, as displayed in two rehabilitation content components, will play a prominent role. The first of these areas will involve the disability management movement encompassed by proprietary rehabilitation. The second emphasis with which we will move into the new era deals with operating in a post-ADA world with ever more empowered consumers of rehabilitation services. To appreciate how we will greet the new century requires an understanding of the influencing foundations underlying these areas, namely *counselor education* and *technology*. How we prepare our professional counselors, in what specialties and toward what goals, and how technology assists both counselors and consumers will define our transition into the new millennium.

DISABILITY MANAGEMENT MOVEMENT/PRIVATE SECTOR REHABILITATION

Without doubt, the field of rehabilitation has expanded exponentially in the last several decades as employment settings for professional rehabilitation counselors in the private sector of rehabilitation have grown. The private sector involved with this continuing trend for counselors does not largely involve either the public or not-for-profit segments which proliferated early in our history and continues on today but the private for-profit sector arena largely fueled by the insurance and health care industries. Hansen and Perlman (1993) noted that private rehabilitation was "a totally unregulated industry two decades ago" (p.12) and is fast becoming a largely licensed and regulated discipline. As professional counseling practitioners take their skills and abilities under the business and corporate egis, they quickly come to fall under scrutiny as to their professionalism, competencies, and qualifications. Hence, the continued emphasis for accreditation, certification, and licensure. Hansen and Perlman (1993) predict that for the year 2000 and beyond, rapid changes and advancements will occur which will call for new rehabilitation education skills and training and which will profoundly influence rehabilitation in the next millennium. Their predicted changes are:

1. Labor market information-changing occupational patterns and job requirements

2. Workplace technology/assistive technology advancements as related to job accommodations

3. Ergonomics

4. Placement techniques, issues, and trends (p.13)

In each of these content areas, technology will be in the form of software packages for learning, pattern observation, job requirement testing, job accommodations potential, ergonomics and placement (i.e., job openings and listings which will continue to proliferate). Hardware and computer-assisted devices will also be invented, come to the fore, and be used increasingly by a wide variety of counselors and consumers to expand their effective environments. Examination of any professional rehabilitation counseling newsletter, bulletin, or announcement carries with it already a vast array of paid advertisements for new hardware, software internet access, and devices to assist the counselor in his or her job. As new and better technology becomes available, that, too, will be offered to the field. As with all things commercial, those technological advances which truly advance the field through efficiency and effectiveness will, like the most efficient and effective of the private for-profit agencies, organizations, and facilities, be able to survive and thrive into the new millennium.

Traditional rehabilitation counselor education programs have not generally instructed in such cognate areas as workers' compensation, long-term disability, bodily injury liability, and automobile no-fault claims (Lynch & Herbert, 1986); none of which are emphasized by the Council oJ39n Rehabilitation Education (CORE). Many rehabilitation counselor training programs are, however, considering offerings geared to the needs of the new millennium, recognizing the fact that more and more professional counselors are encountering these speciality areas (Kilbury et al., 1990). Havranek and Brodwin (1994) provide a listing of potential course offerings which includes:

Computer Technology
Employee Assistance Programs
Work Hardening
Work Transition
Workers' Compensation
Forensic Rehabilitation
Disability Wellness Management

The beginning, basically within the last decade, of a real impetus toward the disability management movement brings proprietary rehabilitation in all its forms, especially the industrial rehabilitation component, into the forefront as we begin the new millennium. Industrial rehabilitation, defined over a decade ago by Matkin (1983, 1985a, 1987), is simply the provision of rehabilitation services to return injured workers to employment. More and more, the identification, evaluation, development, utilization, and training involved in the commitment to return workers to work will involve technology, both in determinations and in applications and follow-ups. The required coordination and cost-effectiveness noted by Boggs and Growick (1994) will be achieved through technological advances and their application. In the same manner that in 1985 it took six fibers in a fiber-optic line to carry a single television broadcast, and now one fiber can handle 700 such broadcasts (Maney, 1998), proprietary rehabilitation of the future will demand newer and better technology as the only way to be competitive and stay in business. Business, industry, and employers of all sorts see the next millennium as one in which the disability management movement reigns both legislatively and as a matter of practicality. For employers the future portrays the disability management movement as a "win-win situation that addresses the reciprocal economic and humanistic needs of the true stakeholders in disability management, namely, employers and employees" (Habeck et al., 1994, p.198).

CONSUMER/COUNSELOR EMPOWERMENT

The empowerment philosophy that for the last decade has spearheaded important social changes is a result of the disability rights movement culminating in the passage of the Americans with Disabilities Act of 1990 and the Civil Rights Act of 1991 (Hardman et al., 1991; Middleton et al., 1998; Riggar et al., 1991). Hahn (1991) contended that the emphasis of the "minority-group" paradigm as seen in these laws is supported by three major postulates. Hahn basically contended that adverse public attitudes are the basis of most barriers, that the climate and environment are shaped by public policy, and that our public policies are reflective of social attitudes (p.17). He noted that

"the ubiquitous obstacles confronted by citizens with disabilities cannot be considered purely accidental or coincidental; instead, they may be viewed as outcomes of the conscious or unconscious sentiments of the dominant nondisabled majority" (p.17).

One footnote to our future is illustrative of just such obstacles or sentiments.[1] That influence is the "client vs consumer" politically-correct terminology which is constantly changing. For years, those with whom we worked were clients, or in medically-oriented settings, patients. Now we have seen a strong trend toward the less passive term, consumer. However, because a consumer is one who consumes, wastes or uses-up things and resources, many cling to client as a preferred term. This raging, perhaps tempest-in-a-teapot, debate has consumed (wasted, used-up?) much journal space (e.g., Nosek, 1993; Rhoades et al., 1995; Thomas, 1993a & b). The concern, however, is legitimate. The problem not easily solved, and each professional counselor must determine where or not the term consumer has become institutionalized and colloquial, or, whether like other groups in our society, identification will likely be forever changing. One recalls an issue of a professional journal some years ago in which one article had the term American Indian in the title while another article used the term Native American in its title. Additionally, one of the articles used the term Indigenous American synonymously throughout the manuscript. Both articles listed authors from different tribes who were of different origin. In these areas, we often find that we follow terms that are prescribed in law and statute, that are part of grants and other funding mechanisms, or what those of the defined group who are in visible positions dictate. As Nell C. Carney (1992) stated: "My presence as a disabled person is regarded as 'representative of people with disabilities'; and therefore, the influence of consumers is the cause for the positive changes that have occurred during my tenure as Commissioner Rehabilitation Services Administration, U.S. Department of Education" (p.193).

The empowerment approach, as delineated by Emener (1991), reveals the consumer and the professional rehabilitation counselor as in the forefront in this social service and civil rights movement. The continually emerging role of the counselor as advocate, information disseminator, and trainer (Boone & Wolfe, 1995), while maintaining

[1] Client, consumer, patient, participant, shareholder, stakeholder, ward, dependent, subject, customer, etc.

"as a strong core valuing of holistic-humanistic empowerment related to personal development and interpersonal and social concern," (Kelly, 1995, p.648) blends immaculately with the history, the present, and the future role and function of professional rehabilitation counselors. As perceived by Bellah et al. (1985), our history and traditions, indeed the focus of rehabilitation in this country today as delineated by the ADA and the Civil Rights Act, reveal "a tradition, or set of traditions, deeply rooted in the philosophical and humanistic...to more than a small extent, the religious history of the West" (p. 301). What guides us into the new millennium is what we hold dear–our values, views, and ideologies that provide for an orientation of human potential and the good life (Christopher, 1996). We enter this new time being assured that professional counseling has, as shown by Sexton and Whiston (1996), demonstrated the value of services, provided evidence of successful interventions, and maintained techniques with proven records of effectiveness (p. 588). These are now "established facts" (Orlinsky, 1994, p. 352).

The empowerment approach then involves "modifications and controls both internal and external to the individual" (Emener, 1991, p. 8). For professional rehabilitation counselors, this goes directly to the commitment to facilitate and maximize opportunities. In this realm, technological advances, particularly assistive devices, have expanded the horizons of persons with disabilities. With greater capacity to have control and authority over their own lives with technological assistance (internal), they now seek to gain not just what people need but what people want (external). Perhaps Condeluci (1989) said it best when he offered that "the concept of community integration and the empowerment model have their roots in social vaporization, right to choose and risk, individualization and consumer control" (p.16).

The next millennium will see continued freedom and liberty for people with disabilities as ever-developing and increasing technological advances enhance the quality of life and the happiness of each person. As Vash (1991) contended, it will be "law-making...which will provide freedom and equity to groups of people,...while transcendence will aid the individual's step toward liberation of a different kind" (p.17).

COUNSELOR EDUCATION

Education in the new millennium will be seen as the true establishment of long-distance approaches and computer-assisted instruction for professional counselors, both pre-service and in-service. Long-distance education (LDE) is not new, in fact having been used relatively effectively for many decades (Moore, 1996). Originally as correspondence courses and then remote sites and meeting with groups of students (LaPidus, 1998), recent technological advances, specifically the World Wide Web (WWW) and Interactive Television (ITV), have afforded new opportunities and advantages for rehabilitation counselor education and training.

The marketplace for higher education is changing rather dramatically. Future trends suggest that in order for universities and academic institutions to remain competitive, nontraditional and place-bound students cannot be ignored. The National Business Alliance (1997) reports that current students are older, more likely to attend school part-time, and are working. Consequently, the opportunities for LDE instruction for credit and noncredit course work, short courses, and conferences offer significant potential for serving nontraditional counseling students, many of whom are place-bound or even home-bound. As such, faculty members and university administrators at many post-secondary institutions are preparing in the new millennium to offer their programs with LDL and ITV technologies (McCollum, 1997). The National Center for Educational Statistics noted that more than a third of higher education institutions offered distance learning courses in fall 1995 (U.S. Dept. of Education, 1997). They estimated that more than 25,000 distance education courses were offered by higher education institutions in academic year 1994 and that the majority of institutions believe that increasing student access is an important goal for their LDE programs. In the 1998 edition of *Peterson's Guide to Distance Learning Programs,* over 700 accredited four-year colleges and universities in the United States and Canada are listed. Consequently, it is clear that as learning never ends (Riggar et al., 1993), and training never ends (Barrett et al., 1997a), the professional rehabilitation counselor in the new millennium will receive much or all of his/her initial education and subsequent training via LDE through ITV, WWW, or combinations thereof.

There is no end to the manner in which computer-assisted instruction (CAI) will be used in the future. For a variety of reasons, not the least of which are unfamiliarity, lack of training, absence in current professional rehabilitation counselor education classes, lack of validity and effectiveness studies, etc., Sampson and Krumboltz (1991) found that "the underrepresentation of CAI in the counseling literature reflects the underutilization of CAI in counseling practice...that the underutilization...is an important barrier to the effective delivery of counseling services" (p.395). For many of the same reasons, Gilbride et al. (1996) found that graduate rehabilitation counseling students who used the Internet, particularly a listserve discussion group, felt that the system assisted them to communicate with faculty, staff, and peers alike, and by the end of the semester, "dramatically increased their opinion of the usefulness of the Internet" (p.47).

While still considered in its "infancy" (Chan et al., 1990), the availability for a number of years of computer simulations for that traditionally most all-encompassing of professional rehabilitation counselor skills, specifically caseload management, (Riggar & Patrick, 1984), is continually being evaluated and validated (Chan et al., 1989, 1993; Mecaskey et al., 1989). For many years, computer-assisted testing and computer-assisted career guidance have been used and accepted (Sampson & Krumboltz, 1991; Vander Kolk, 1995). There was a time in the not to distant past when such uses were resisted as they were felt to eliminate the "human element," were not sufficiently accurate, and a wide variety of other rationales which, over time and given the repetition of numerous validity studies, slowly came to become not only normal and reasonable in practice but a mainstay of much of what we do today. Several decades ago we began to notice the efficacy of CAI (Chambers & Sprecher, 1980), and in the new millennium we will see the fruition of many years of work. The new millennium will find counselor education as a field in which CAI courses and conferences via LDE will be largely involved with the computer-assisted manner by which we teach and perform professional counseling.

TECHNOLOGY

Technology is not new in rehabilitation. Given the use of prosthetic and orthotics, crutches, wheelchairs, and various tools and devices

to make activities of daily living possible, Americans with disabilities have been using devices and tools (Assistive Technology) since someone stepped on Plymouth Rock with their "peg" leg. What is new, however, and new within the last few decades is the advent of electronic and computer technology. The extent of computer assistive technology is demonstrated by the most widely used operating system today (Windows 95) incorporating "Accessibility Properties" that allow people to make changes to computer input (i.e., keyboard, mouse) and output (i.e., sound, display) to compensate for functional limitations due to disability. The use of toggle and filter keys and pointer control options allows people to input information despite psychomotor skill deficits. Change to the screen display or audio output allows people with sensory deficits to access computer-based information. Puckett et al. (1991) contend that contemporary legislation concerning technology can be traced to the 1983 Technology and Handicapped People study by the Office of Technology Assessment, U.S. Senate Committee on Labor and Human Resources commission (p. 273). Soon afterward, assistive technology (AT) applications began to develop at a rapid rate for professional counselors and their consumers. Table 1 briefly illustrates some of the major milestones in the earliest beginnings of advanced technology in rehabilitation.

In less than two decades technology has leaped into the professional rehabilitation counselor scene and many people and programs are scrambling to catch up. Crimando (1997), in his chapter on the Role of Technology: Engineering and Computers, extensively examines the status of rehabilitation engineering and assistive technology today. He notes that the literature is replete with examples of technological devices; many being found in *Assistive Technology*, the *IEEE Transactions on Rehabilitation Engineering*, the *Journal of Rehabilitation Research and Development* (p.237), and *Closing the Gap* (www.closingthegap.com). In his research. he found considerable advancements in prosthetic and orthotics, wheelchairs and mobility devices, and adaptive worksites and tool modifications. Crimando stated that:

> From low-tech adapted tools and adaptive switches, to the now-ordinary personal computer and Internet, to high-tech prosthetic, orthotic, and robotic systems, technology exists or can be designed to help persons with disabilities perform functions that previously were not imagined possible. (p.245)

Table 1.
TECHNOLOGY

Year	*Legislation*	*Results*
1983	Technology and Handicapped People study	Role of technology and assistive devices
1986	Amendments to the Rehabilitation Act	Assessment and prescription of assistive devices
1986	Social Security Amendments	Tax sheltering to purchase technology
1987	Developmental Disabilities Assistance Act Amendments	Three portions added to include technology
1987	Elementary and Secondary School Improvement Act	Funding and acquisition of equipment
1988	The Technology-Related Assistance for Individuals with Disabilities Act	Expands availability of devices
1988	Medicaid Amendments	Expand existing program
1990	Americans with Disabilities Act	Access to technology; tax incentives to small businesses; reasibable accomodation
1990	Amendments to Individuals with Disabilities Education Act	Consider student needs in technology areas
1990	Television Decoder Circuitry Act	Design standards
1992	Amendments to 1073 Rehab Act	Rehabilitation technology stressed
1997	Reauthorization of IDEA	Need for AT be considered each time an IEP is done

The new millennium will see the now very high costs of advanced technological devices drop to manageable levels leaving imagination and innovation as guides for the future. Perhaps our biggest potential concern will be the training of professional counselors to be able to themselves adapt to these new changes for themselves and their consumers. A variety of authors (Justesen & Menlove, 1994; Puckett et al., 1991; Strauss, 1991) have offered curricular interventions and suggestions as well as developed education and training programs which provide adequate assistance to professional counselors in modern technology. Given the wide variety of areas in which AT is currently being integrated: with infants and children (Parette, & VanBiervliet, 1991), testing (Chubon et al., 1991; Clawson, 1997), visual impairments (O'Korn & Wheaton, 1995), etc., and that to which computers are operating information-based human service organizations (Moriarty, 1991), job-matching (Wong et al., 1992), determining lost earning

capacity (Cutler et al., 1995), recognizing voice commands (Goette, & Marchewka, 1994), even using brain power via an implant to move a cursor across a screen through direct communication between the brain and a computer (Associated Press, 1998; Talan, 1998), etc. are but a few of the areas in which technology is more and more being integrated. Consumer-driven models (Reed et al., 1995) based on common sense and empowerment are moving to the forefront to the new millennium.

Availability and cost will be diminished as viable concerns in the new millennium as production costs go down and more and better devices, in competitive settings, are available. Education concerns for professional counselors, consumers, and indeed the public at large will be delineated, defined, and implemented. The last major hurdle to advanced technology in the new millennium will be the administrative procedures and policy "gridlock" which Puckett et al. (1991) find at both the state and federal level as the "greatest barrier to broader application of assistive technology" (p.273). Fortunately, that, too, in the new millennium, will diminish as scribes gave way to the printing plant and typewriters gave way to word processors, and as "key boarding" will soon give way to voice controlled machines. Despite the vast research on change and change management (Crimando et al., 1988; Crimando et al., 1989; Riggar et al., 1989) and its obvious lack of application in most state and federal bureaucracies, change will take place as the constant and obvious need and use of advanced technology by consumers, often impelled by computer and AT literate professional counselors who have gained their knowledge preservice or in-service, becomes a constant refrain in the future. This simple fact of progress is especially true in the computer and associated technology arena as the American quest for the newest, the most efficient, the most effective, and the best will be constantly heard in the new millennium by counselors and consumers alike.

As will be seen in the next chapter the opportunities afforded by AT will open doors always thought locked, level paths always believed too rocky, and reveal a horizon always before blocked by barriers.

THE FUTURE

The new millennium will begin with two major emphasis areas which are guided and focused through the expanded and innovative exercise of computer-assisted counselor education and advanced technology. Future education and technology as evidenced through their manifestations in the disability management/private sector movement, and the empowerment of those involved in the rehabilitation counseling process will expand the freedom and liberty of all in society. The changing nature of work and worker skill requirements mandates that we must be in earnest in the new millennium to "attain and maintain satisfying and enduring life goals" (Ryan, 1995, p.8). This development over a life span brings, as noted by Myers (1992), wellness, prevention, and development to the forefront as guides for professional counselor education and for the design and intent of assistive technology as well. The diverse needs of ever more heterogeneous consumers of rehabilitation (Ting & Fitzgerald, 1996) will fuel the need for health care reform through managed care, public health programs, or national health care for persons with disabilities (Alston, 1997). Particularly as the population ages (Hansen & Perlman, 1991) in the new millennium, rehabilitation, already the fastest growing segment of health care, will continue to expand (Frank, Gluck, & Buckelew, 1990).

Counselor education in the new millennium will address professional counselor career opportunities which include mental health, substance abuse treatment, employee assistance programs (Koch & Rumrill, 1997), and will continue to expand, as noted, in the currently blossoming emphasis areas of geriatric rehabilitation, medical/allied health case management, disability management, and private practice/consultation. In all of these areas, computer-assisted instruction, both preservice and in-service, will continue to be developed not only for their efficiency and effectiveness but for the increasing enrollment of professional counselors to-be, and counselors who intend to continue their education, training, and development to attain, maintain, and integrate the new technological advances with practice.

The future for professional counselor education, coming more and more as noted under the egis of government and business-oriented industries, will be the increased emphasis for promoting professionalism, the setting of standards, and the medically-based orientation

toward advanced professional counselor specialization (e.g., the Certified Case Manager, the newly created Substance Abuse Certificate under the CRC, the National Certified Addiction Counselor and Master Addiction Counselor under the NAADAC). The continuing demand for quality and accountability (Anderson, 1992; Steenbarger & Smith, 1996) will promote the incorporation of professional development activities into counselor education programs and practice (Spruill & Benshoff, 1996), renewing the call for certification research and credentialing (Leahy & Szymanski, 1993; Rubin et al., 1998). Also in the new millennium will be the end to the on-going debate of counselor specialties vs. basic preparation (Goodwin, 1992) as the industrial-medical model will prevail resulting in counselor education programs that will perform both functions basic preparation first and then specializations built upon the core professional counselor curriculum for employment and competent practice with clients (Hosie, 1995).

Part of the specialization in counselor education will be based on technology. In the same manner as core and specialization, the technological expansion will fill both the core curriculum through computer-assisted instruction, testing, simulations, etc., and will become a specialization with its own venue. The "tool kit" of the assistive technology specialist (Kaplan & Edyburn, 1998), who is first and foremost a professional counselor dealing with the whole life of the consumer, will include devices that today only the imagination and science-fiction shows reveal. High-tech prosthetic, orthotic, and robotic systems coupled with sensory or brain-controlled computers are already available. While still experimental, in research laboratories, and very, very expensive, what is already on the drawing boards as we begin to enter the new millennium is awe inspiring. In a private conversation a few years ago with a Bell Laboratories (Lucent Technologies) physicist, one of the authors herein stated, "It's not just talking to computers that counts, because I can type quickly, but when computers can talk back to me that I'm interested!" The scientist stated "We have those." Of course, they do...and someday we will all be able to be assisted by that technology no matter how we communicate with the computer which will do for us what we cannot do easily for ourselves. That is the future of advanced technology.

We would be remiss, however, if as we move forward in this text we did not reiterate that while the philosophy of professional rehabil-

itation counseling is People First and that we advocate for consumer choice and empowerment (Maki & Riggar, 1997), that technology in and of itself does not assure a rosy future. Concerns about biomedicine and genetics (Houser & Lash, 1996), disability policy and the laws (Maki & Riggar, 1991a & b), and confidentiality, privilege, malpractice and forensics (Vallario & Emener, 1991) will not be solved by technology itself. In fact technology itself brings its own unique set of problems with it to professional counseling. As good as technology is and will be (McFarlane & Turner, 1995), it carries with it problems unique to its application (Eldredge, 1995; Menz, 1995). While technological solutions can be found for many of these future applications the more humanistic concerns of professional counselors may continue. Job satisfaction and personnel turnover of professional personnel continues at very high rates (Barrett et al., 1997d; Garske, 1996; Gomez & Michaelis, 1995) and the addition of new technological demands may exacerbate the problem. For solutions, we can look to ourselves and our mandate (Maki & Riggar, 1997) and reiterate our philosophy that "embraces a person's right to choose his or her relationships and goals, both personal and vocational" (p.5).

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Chapter 4

ASSISTIVE TECHNOLOGIES

DONNA R. FALVO

Continuing advances in technology have resulted in the development of tools and devices which enable people to achieve personal goals and to move toward future achievements. More specifically, technology has played an important role in the field of rehabilitation, helping individuals with disabilities achieve increased functional capacity and independence and there is every reason to believe that technology will continue to play this important role in the future. Because of technological advances and the application of these advances to disability, individuals with a variety of functional limitations have been increasingly able to adapt to their environment. As we end the current century and move into the new millennium, rapid growth of technology and development of new technologies will improve accessibility of home, education, and work environments for persons with disability resulting in increased social, educational, and employment opportunities.

The number and sophistication of assistive devices available to individuals with disabilities may be expected to increase dramatically in the next millennium (Scadden, 1991). With the proliferation of technology, however, steps must be taken to assure that as devices are developed, they truly meet the needs of the individuals for whom their use is intended. There is an urgent need to plan and implement coordinated delivery systems which will assure equitable distribution of resources, as well as quality assurance for and appropriate use of, assistive devices available.

Assistive technology and associated services, if they are applied effectively, must be viewed within the context of the life of the individual . Having technology available does not necessarily mean that the resulting assistive device will be useful or that it will be used. Many

factors aside from availability of specialized equipment determine its effectiveness. Consistency and integration of approaches to the use of assistive devices and approaches which are built on similar assumptions will, none the less, help to maximize their benefit.

HISTORICAL PERSPECTIVES

Assistive technology is neither a new concept nor an invention of the modern world. Special tools or devices have been used since the beginning of civilization to assist individuals in meeting needs or reaching goals. Throughout time, the development of tools has assisted in the evolution of humankind and of society as a whole (Campbell, 1982). Technology has been applied in a variety of situations throughout history to solve practical problems by developing alternative methods to reach goals. This application of technology has been utilized not only to enhance quality of life, but in some instances to sustain it. One of the first assistive devices dates back to prehistoric times when crude stone tools for cutting and chopping were produced (Semenov, 1964). The development of these tools marked the beginning of cultural, rather than biological, adaptation to the environment. This initial use of tools also helped individuals compete and survive in their environment despite existing barriers. Importantly, this initial cultural adaptation was an important step in the process of helping individuals gain control by shaping their environment rather than passively allowing the environment and its constraints to totally shape individuals in it. As the sophistication and diversification of tools widened the horizons of culture, there was accompanying development in life habits, and a consequent evolutionary continuum in technological developments.

Over centuries, as human populations grew and began to migrate to new environments, new problems were encountered. For example, resulting new environments necessitated the development of new tools in order to adapt to disparate environments. Hence, assistive technology always has been defined in terms of the specific needs of individuals within a particular environment. Using assistive technology to help achieve increased functional independence in the environment, then, is not a unique application of technology. Rather, it is an exam-

ple of how technology can be used to adapt to changing needs and environments. Although assistive devices of today show little resemblance to those developed in prehistoric times, the broad concept of assistive technology and its application to practical problems today is not much different than the concept as originally applied when the first assistive device was developed.

LEGISLATIVE PERSPECTIVES

In modern society, assistive technology also can be defined legally. With regard to individuals with disability, a number of pieces of legislation have emphasized assistive technology (Office of Special Education and Rehabilitative Services, 1992). One of the most inclusive definitions of assistive technology is found in the Technology-Related Assistance for Individuals with Disabilities Act of 1988 (29 U.S.C. Sec. 2202(S)). The definition of an assistive technology device as stated in the Act is:

> Any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve ,functional capabilities of individuals with disabilities.

How the devices are provided are also included in the Act, which defines assistive technology services as:

> Any service that directly assists an individual with a disability in the selection, accession, or use of an assistive technology device.

The 1988 Technology-Related Assistance for Individuals with Disabilities Act provides for active participation of individuals with disabilities in all aspects of service. This would include the choice of assistive technology devices to best suit the individual's needs, as well as the individual's assessment of the device's effectiveness. Because of the 1994 Amendments to the Technology-Related Assistance for Individuals with Disabilities Act, individuals with disabilities are now able to take legal action if they are denied access to assistive technology to which they are entitled.

MATCHING PEOPLE WITH TECHNOLOGY

Assistive technology has been used to produce tools or devices which can enhance independent functioning as well as quality of life for individuals with disabilities. Devices of today can range anywhere from low-tech or do-it-yourself devices, such a paint can opener used to open jars when there is reduced hand strength, to devices as sophisticated as computer software for individuals with cognitive impairments. Regardless of the sophistication of assistive devices in the future, the most effective device will still be one which individuals are willing and able to use in their own environment to meet their specific needs. Therefore, before a decision about whether or not an assistive device is needed, or whether a particular assistive device is appropriate, a number of different factors must be considered. When determining the appropriateness of assistive devices, aside from functional limitations specific to the individual's disability, other factors such as cost, availability, and the degree to which it actually helps improve functional capacity, will still need to be considered. In making these determinations, the individual's specific goals, tasks within a given environment, psychosocial incentives and disincentives, personal characteristics, abilities, and preferences are key factors.

ASSESSING THE ENVIRONMENT

The individual's physical as well as psychosocial environment impact on the usefulness of an assistive device. Consequently, characteristics of the individual's environment, both physical and psychosocial, must be considered. Just as the type of assistive devices needed varies according to an individual's needs, so will the number of assistive devices needed. Few people function in only one setting. Thus, individuals with disabilities may require specific devices for activities of daily living, different devices in their place of work, and yet different devices in social and recreational settings. Consequently, not all people with similar disabilities require the same type nor the same number of assistive devices. The type of needed assistive device also depends to a large extent on where the equipment will be used, tasks and activities required in each environment, and the extent to which tasks would be enhanced by use of the device.

Architectural accessibility and the amount of environmental support needed for use of a device, also are important considerations. The physical environment in which the assistive device is to be operated must be assessed, and obstacles which could interfere with its use must be identified. Assistive devices may not be necessary to increase functional capacity within a given environment. At times, rather than use of an assistive device, environmental modification alone may increase the individual's ability to function. As society becomes increasingly aware of the need for universal design which in turn creates environments which are more accessible for all individuals, some physical barriers which exist today may need fewer modifications or be nonexistent in the future.

In addition to the physical environment, the psychosocial environment also must be considered. The amount of support and encouragement the individual receives in their environment for utilizing a particular device, may determine the degree to which it is used. If, rather than being obtained in response to the individual's perceived needs, the device has been forced upon the individual by others, the potential for successful use of the device is diminished.

The cultural environment in which the individual functions also plays a major role. For example, in the deaf community some assistive devices may not be accepted, although those in the hearing community may view the device as important to improve functional capacity. Likewise, individuals in older age groups may be reluctant to utilize some assistive devices because they perceive the device, and their need for it, as focusing attention on their age.

INDIVIDUAL NEEDS AND GOALS

Whether today or in the next millennium, before any type of assistive device is selected, a thorough assessment of the individual's preferences and needs must be conducted. It should not be assumed that no viable alternatives to specific types of assistive technologies exist. Although it is likely that individuals with severe disability will require high technology devices, assumptions should never be made without assessing each individual's specific needs and desires. Access to consumer-responsible assistive devices and services are federally mandat-

ed; however, individuals differ in need, value, motivation, and expectations, all of which can affect assistive technology utilization. Furthermore, all assistive devices should be matched to the individual's capabilities and temperament. Likewise, individuals must believe that the device will benefit them in some way, either by helping them to meet specific goals or by increasing autonomy and general quality of life.

The use of assistive devices, and the type of device used may change over time. Moreover, the type and number of assistive devices needed may change as individuals age. If a person's disability is progressive, different assistive devices may be needed over time to accommodate additional limitations. In other instances, different devices may be required because the individual's lifestyle has changed. Human circumstances are not static. To assure maximum benefit of assistive technology, flexibility in evaluating the continuing and changing needs of individuals is important today and will be in the future.

Assistive devices vary in complexity. While some assistive devices are relatively easy to use, others require considerable training and practice before the individual is able to use them effectively. The most effective assistive device is one which individuals are comfortable using and one which meets their needs in their own environment. For some individuals, the use of technological devices may be intimidating. Anxiety or insecurity about one's ability to use a device may result in avoidance or perhaps even abandonment of the device. Furthermore, the more sophisticated the device, the more complicated it may be to use. As more technological advances are made in the future and devices become more sophisticated, individuals with little exposure to technology and who are intimidated by it, may be resistant to their use. On the other hand, younger generations who have had greater exposure to technology may have increased acceptance of a larger number of assistive devices.

APPRAISAL OF ASSISTIVE DEVICES AND ALTERNATIVES

As new technologies become available in the future, there will be greater choice of devices to meet specific needs. Ironically, the num-

ber of choices available may make it more difficult to choose the device best suited to the individual. Assistive devices, need to be assessed realistically. Information regarding the degree to which research substantiates performance claims made by the manufacturer of the device is important now and will be even more important with the advent of new technologies in the future. When a device is new on the market, information about whether it has been appropriately evaluated, and under what circumstances it has been evaluated, can help the consumer and his or her counselor determine quality. Information related to how and under what circumstances the device was tested, performance results, and safety and durability information should be obtained. If the assistive device needs to be upgraded and whether the device can be expanded as new technology becomes available to accommodate new features will be increasingly important to note. In some instances, compatibility with other assistive devices also may be important to determine.

While the initial purchase cost of a device must be assessed, maintenance costs, availability of resources for repair and associated costs, and costs of replacement cannot be discounted. As more technological advances are made, it is likely that maintenance provisions will be included by the manufacturer. However, it still will be necessary to identify resources to cover maintenance costs.

The degree to which a device accurately reflects an individual's preference, lifestyle, and values are key issues to be considered. In the future this will be just as true, and perhaps even more so as more sophisticated devices are developed. Availability of alternative devices should be weighed against more elaborate devices in the context of the specific needs of the individual. Whether or not a device is portable may determine if the individual can use the device in more than one setting. The degree to which assistance is needed to learn to use a device and the extent to which the device can be used independently also are factors which impact on effective utilization.

Although emphasis is placed on the degree to which a device increases functional capacity or quality of life, aesthetics of the device also cannot be ignored. The appearance of a device, its ease of use, and how disruptive its use may be in certain settings can be determinants of an individual's willingness to use it. If an individual feels conspicuous using a device, believes the device is stigmatizing, or if a

device interferes with social interaction, it may be abandoned. Physical and cognitive abilities needed for use of an assistive device also are important factors in their use. Ergonomic aspects, as well as an individual's ability to learn to use a device and maintain it, should be explored. A number of physical factors related to an individual's specific disability may determine the level of energy needed to operate the device as well as physical comfort or discomfort experienced with its use. In turn, these factors may contribute to the ability or inability to use a particular assistive device. If use of a device requires cognitive or perceptual skills, but the cognitive deficits are present in these areas, use of the assistive device may hinder rather than help an individual's ability to achieve enhanced functional capacity.

ASSESSING RESOURCES AND ALTERNATIVES

The best assistive device is not always the most expensive. Locating the best assistive device requires (1) close examination of costs/benefits of the device as opposed to available alternatives, and then (2) closely matching the device to the individual's specific needs and resources. Funding for an assistive device, as well as for support services needed for its continued use, can be problematic. If specialized treatment or personal assistance are required to use a device, resources should be identified prior to obtaining it.

Although cost is important, of more importance is the cost-benefit ratio. Alternative devices, although perhaps less costly, are not cost effective if they do not help the individual reach his or her goals, or require expensive supplemental services for their use. On the other hand, even though the initial cost of an assistive device may be high, if cost is decreased over time as a result of reduction in supplemental services needed, or if the level of individual productivity is increased as a result of the device, the use of the device may be cost-effective.

Sophisticated, high-tech devices can be expensive. In the future, additional technological advances may decrease the price to manufacture key components. Consequently, cost for some devices may become lower. Despite lower costs, funding may still be a barrier to individuals who are attempting to obtain the most appropriate device. Funding resources currently range from a variety of public and private

sources including federal and state programs, service organizations, and private insurance or private loans. Currently, there are often features of these agencies or organizations that restrict their ability to make assistive technology fully available to those they serve. Eligibility criteria, exclusionary screening, and limitations related to an agency's jurisdiction and mission may negate services for a number of individuals. In an age of managed care and shrinking resources, the cost of assistive technology makes it even more important to determine the best fit for an assistive device to meet an individual's need. Unfortunately, when evaluating the cost-benefit of assistive devices, the cost-benefit is often measured in strictly monetary terms. The benefit to the individual in terms of quality of life, self-respect, and personal autonomy are among technology's most important benefits; however, these measures of cost-benefit may not be considered and certainly are more difficult to operationalize. How funding for assistive devices and how managed care issues will be resolved in the next millennium are yet to be determined. If a more equitable solution is to be reached, however, administrative mechanisms which decrease waste and duplication and measure outcomes in more than economic terms will need to be developed.

MEASURING OUTCOMES

Because much assistive technology is costly, there is increasing responsibility to demonstrate that the device did, in fact, make a difference in the person's life. How this difference is measured and quantified is a substantive issue. Currently there is little consistency in defining outcomes to be measured or uniformity of types of measures to be used. Issues of personal values, program values, as well as functional status and job status are all outcomes which could be measured. However, outcomes still are often measured in mostly economic terms.

Measurement of consumer satisfaction with a device cannot be ignored since this factor alone may determine the degree to which a device is used. Assistive devices only can be maximally effective, both in terms of meeting goals and in terms of cost-effectiveness, if they are appropriately utilized.

In the future, it will be important to operationalize outcomes which include subjective as well as objective measures if true cost-benefit is to be determined. Fuller customer participation in determining the most appropriate assistive device for their particular needs should help to produce optimal outcomes.

TYPES OF ASSISTIVE DEVICES

Assistive devices can be used in any area of an individual's life and can range from low-tech to high tech or highly customized devices. Assistive devices are currently used for activities of daily living, transportation, occupationally-related tasks, business and social interactions, and recreation. Some devices are used in multiple settings for multiple purposes, while other devices are specifically designed for one particular task or goal. As technology evolves in the next millennium, it is possible that more compensatory technologies will be developed which will enable persons with disabilities to more fully adapt to their environment to meet their needs. The increased use of infrared and other forms of wireless communications, optical fibers, and communication satellites will further enhance the ability of individuals with disabilities to become more fully integrated into activities which are now problematic.

ACTIVITIES OF DAILY LIVING

Devices used in general activities of daily living such as grooming, eating, bathing, toileting, and dressing are generally low-tech aids, and although they usually are less expensive, they are vital to independence and to reaching goals in other areas. The type of device needed for activities of daily living is determined by the type of functional limitations present and the environments in which it is to be used. An individual's need for devices and the type of device needed may change as he or she moves to different environments. Services used in the home environment, for example, may no longer be applicable when the individual leaves for college. Everyday devices which help an individual at home may not be appropriate on a business trip. The

appropriateness of each device should be considered in the context of the setting in which it is to be used.

Technology already has provided assistive devices that increase functional capacity. Use of microwave ovens, electric can openers, and other electronic devices, to name a few, are used by people without disability as convenience, but the same devices also have done much to increase the functional capacity and independence of people with disabilities. In the future, increased sophistication of computers, robotics, and other electronic devices may offer increased potential for functional independence in activities of daily living for persons with disabilities.

MOBILITY AIDS

Current low-tech aids, such as canes or walkers, or high-tech aids, which include manual or power wheelchairs, are used to help individuals achieve mobility when there is a functional limitation. Significant progress already has been made in the development of wheeled mobility devices. Today, microcomputer-controlled power wheelchairs and powered wheelchairs with puff-sip controls provide individuals with severe disabilities with increased mobility which decades ago would not have been possible. New technological advances may provide wheelchairs which have instrumentation to alert users that they are too close to objects or which decrease power when there is an object in the path (Galvin & Scherer, 1996).

If transportation is considered as a mobility need, the development of adaptive devices to modify vehicles including hand controls, steering devices, as well as other adaptations, already has made significant impact on the ability of individuals with disabilities to be independent in a wider environment. Van conversions, which include wheel-chair lifts, are other examples of technology which enable individuals with disability to achieve greater independence.

As technology advances in the next millennium, the sophistication of mobility and transportation devices certainly will be enhanced. It is possible, however, that without public awareness, environmental constraints still will be a barrier to full adaptation. Wheeled mobility aids, as well as transportation aids, are only maximally effective when the

environment accommodates their use. Environments in which there are no sidewalks, or in which sidewalks are in disrepair, make the most efficient mobility aid less effectual. Maximum attainment of goals of the individual using a highly sophisticated van cannot be attained if there is no accessible parking available, or if the parking which is available is inadequate to allow exit from a van. Gas stations which only have self-service pumps available provide barriers for individuals who are unable to pump gas, no matter how sophisticated the van they are driving.

AIDS FOR BLINDNESS AND VISUAL IMPAIRMENT

Significant technological advances have been made so that assistive devices are available to enable individuals who are blind or visually impaired to have access to information and safe travel. Many of the advances available today are due to computer technology (Scadden, 1991).

Technological advances are only useful if they are accessible to individuals. Graphical user interfaces, which widely use visual symbols and in which a mouse is used for making selections rather than typed commands, are virtually inaccessible to individuals who are blind. The development of devices which enable individuals who are blind or visually impaired can provide easy access to a variety of products not currently available. Importantly, these would further increase independence. Voice recognition or computers which can talk back to the user are examples of advances which also could create greater access.

New technological advances give promise to greater mobility and access for individuals who are blind. The development of optical-to-vibrotactile prosthesis has made it possible to provide individuals who are blind with patterns of stimulation which allow them to discriminate certain properties of three dimensional space (Miletic, 1984). Research based on advances of optical sensing and computer vision technology has proposed automated vehicle systems which could be developed so that an individual vehicle would be guided to follow a desired or preselected route (Tsai & Chen, 1986). The development of electronically operated travel aids also may enable individuals who

are blind to maneuver through unfamiliar areas to find a street address.

AIDS FOR INDIVIDUALS WHO ARE DEAF OR HARD OF HEARING

Assistive devices for individuals with deafness or who are hard of hearing can be classified as "devices which help the individual communicate with the outside world." Communication devices, for the most part, are devices which use amplification, vibrotactile prompts, or visual cues. Assistive devices which have been developed to assure accessible communication may be relatively inexpensive and easy to implement or more expensive and complex. Technological advances have made it possible for individuals to have access to enhanced communication through devices such as hearing aids, telecommunication devices (TDD), infrared systems, and real-time or closed captioning. These devices have increased the ability of individuals who are deaf or hearing impaired to become increasingly integrated into the hearing world.

Not all individuals who are deaf or hearing impaired, however, believe that compensating for decreased ability to hear is needed. Many individuals who are deaf have a strong cultural identity with the deaf community and may not be receptive to many of the technological advances which are currently available or may become available in the future. Individuals' values and perspectives are an important component in determining the success of assistive devices used with a variety of disabilities. In the case of individuals who are deaf or hearing impaired, assessment of values and perspectives is even more crucial in determining need for an assistive device or whether or not it will be used.

COMMUNICATION DEVICES

Communication is a complex activity which involves perception and integration of information. It is an important aspect of functioning in everyday life both in and outside of the workplace. Communication includes speaking, writing, reading, and hearing, or signing or other

nonverbal means of communicating. Assistive devices to aid in communication currently range from low-tech devices such as communication boards to high-tech argumentative communication devices which are computers. Whether individuals use low-technology or high-technology devices, nonetheless, a certain degree of cognitive and motor ability is required.

Due to the complexity of communication and the varying capabilities and needs of individuals in different situations, no one type of device is appropriate for everyone. The device chosen to augment or enhance communication must be one that meets the specifications of the individual who will be using it. Because communication is such an individual and personal function, the individual using a device is the best qualified to evaluate improved communication outcomes.

The continued development of computer-assisted communication in the future offers optimistic opportunities for individuals with difficulties in communication. Knowledge-based systems, for example, may be able to compensate for mis-communication.

ASSISTIVE DEVICES IN RECREATION

Assistive devices needed for recreational activities, as with all other activities, vary with individual need, interest, and ability. Technology already has created sports equipment that enables able-bodied athletes to achieve far greater records than previously had been expected. Some of the same types of technology applied to recreational devices for individuals with disability have created a new freedom not previously enjoyed.

Obviously, the sophistication of technology used for recreational equipment varies with the activity. Technology needed for assisting individuals in card playing is much different than that needed for helping an individual with a disability in downhill skiing. Not all individuals want to pursue the same type of recreation they enjoyed prior to their disability, while others embrace the opportunity to continue. The largest barrier to individuals continuing recreational activities of their choice after disability, frequently is the bias of those around them, in which certain activities are judged to be unrealistic or inappropriate (Colston, 1991). This bias may continue in the next millennium despite

increased sophistication of devices which could broaden recreational opportunities for persons with disability.

ASSISTIVE DEVICES IN THE WORKPLACE

Accommodations in the workplace do not always require expensive and sophisticated adaptations. Modification of the environment in terms of lighting, air temperature control, or removal of obstacles may be all that is necessary to enable individuals to return to their full functional capacity. In other instances, finding alternate ways to perform a job function or to modify existing devises may be all that is necessary.

As in other areas of an individual's life, high-tech devices are not always the most appropriate or effective way to meet individual need or increase ability to perform a specific function effectively. This will also be true in the future. Focusing on an individual's ability rather than disability, and including the individual in the process of determining what is needed in order to function in the workplace, provides the most useful approach to determining what, if any assistive devices are needed.

IMPLICATIONS FOR COUNSELING PROFESSIONALS

Throughout this chapter, there are numerous implications for professional counselors in the next millennium. Nonetheless, it is important for counseling professionals (e.g., mental health counselors, rehabilitation counselors, social workers, psychologists, etc.) to be sure to consider the needs and preferences of the individual before mobilizing resources to obtain a device for him or her. The most effective assistive device is one which an individual is willing and able to use in his or her own environment to meet his or her specific needs. Functional limitations specific to the individual's disability are only one aspect to be considered before obtaining an assistive device. The individual's specific goals, tasks which they need or want to accomplish within a specific environment, psychosocial incentives and disincentives, personal characteristics, abilities, and preferences are key factors in determining successful use of an assistive device.

IMPLICATIONS FOR THE FUTURE

Technology, from the development of the first primitive tool to the technology available today, has and will continue to shape society. It makes tasks that individuals want to accomplish possible or makes them easier. Technological advances, for the most part, benefit all people, whether a disability is present or not.

Technology has helped to shape society; however, values, attitudes, and economic concerns of society also help to shape how technology will be used. Technological devices are available to able-bodied individuals without necessarily determining the need the device will fulfill or the benefit it will provide. However, individuals with disabilities often are required to be more accountable for how assistive devices will be used and how cost effective the device will be.

As we move into the next millennium, many of the issues surrounding assistive devices which are of concern today will be the same. Although there may be more sophisticated and technologically complex devices available, finding ways to assure that they will be available to all who need them and that they will be available on a equitable basis will be a major issue. Advances of new technology have the potential to create an even greater dichotomy between those who have access and those who do not. Technology is expensive. Devising a system in which cost-benefit is accurately measured, in terms of economics as well as personal goals, will be a challenging objective. When new, more complex technologies are available, adequate training for use and alleviating anxiety which may be associated with use will be a necessity for effectiveness.

CONCLUDING COMMENTS

In the next millennium, if technology is to fully serve individuals with disabilities, it will be important to consider not only technological perspectives of ergonomics and structural design in accordance with specific disabilities, but also to consider the impact of human factors. Human factors such as capabilities, as well as limitations, individuals needs and preferences, and whether the technology which is designed to help will be perceived by the person using it as dehu-

manizing or as an enhancement of human experience will determine both the effectiveness of use as well as efficient use of resources.

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Chapter 5

ETHICAL ISSUES IN THE 21st CENTURY

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Ethical issues present an on-going challenge to counseling professionals. Although counselors may believe that the number of ethical dilemmas is increasing, it is more likely that this belief stems from an increased awareness of ethical dilemmas coupled with ever-changing ethical situations. Like learning, behaving ethically is a life-long *process*.

With this caveat, part of behaving ethically is to anticipate ethical dilemmas and possess the skills (i.e., ethical decision-making skills) to address ethical situations as they arise. As counselors move into the new millennium, the ethical dilemmas they face likely will be similar to current ethical dilemmas, though the specifics of the situations will change. For example, counselors will continue to be challenged in areas such as choice, confidentiality, conflicting loyalties, continuing competence, and dual relationships. However, the changing situations will likely involve (a) technology, particularly the Internet; (b) diversity; (c) choice; and (d) setting-specific issues (e.g., managed care). Also, because ethical codes are not static documents, they periodically are revised. Therefore, counselors undoubtedly will be challenged with revised codes that they need to understand and apply along with the applicable ethical principles (i.e., autonomy, beneficence, nonmaleficence, justice, and fidelity) to these new areas.

THE CHALLENGE OF TECHNOLOGY

The Internet has enhanced the speed with which communication can be transmitted and received (e.g., electronic-mail). As technologi-

cal advances continue, counselors undoubtedly will remain "technologically challenged" as they move into the 21st century. Also, these technological challenges will be accompanied by ethical issues related to this medium of communication, since it impacts on many elements of the codes of ethics for professional counselors.

Counseling via the Internet, or Webcounseling, has been defined as "the practice of professional counseling and information delivery that occurs when client(s) and counselor are in separate or remote locations and utilize electronic means to communicate over the Internet" (National Board for Certified Counselors [NBCC], 1998, p.1). Because of the benefits available to consumers, it is likely that the use of the Internet by professional counselors will increase substantially. According to Weil (1996) "...e-mail discussion groups, online magazines, online support groups, chat rooms, and online psychotherapy [provide people]... with a range of opportunities to use cyberspace for therapeutic assistance" (p. 2). Professional counselors have long been familiar with the benefits consumers can derive from communicating with others who have shared similar experiences. The Internet has greatly expanded the number and type of groups, and nearly any area of counseling concern now has one or more pages devoted to member sharing. These pages can be especially valuable for (a) individuals with less common concerns or disabilities which may preclude sufficient numbers in one physical location, (b) individuals who live in rural areas or for whom transportation may be difficult, (c) individuals who cannot attend meetings at the time they are scheduled, and (d) individuals who are not yet ready to discuss their issues but would benefit from the experiences of others (e.g., rape victims). Because membership in the informal groups crosses state and national boundaries, individuals can learn of others' experiences, including their experiences with various forms of treatment, and the ways in which they have addressed different situations related to their concerns. Future research on on-line support groups will be important for counselors in weighing the benefits of utilizing such groups or informing individuals of their existence and the ethical responsibilities associated with such referrals.

For example, some clients may not question the accuracy of information they obtain when attempting to use the Internet as a substitute for a more traditional counseling relationship. In some situations,

counselors will need to highlight the disclaimers (e.g., "Nothing here is meant to replace professional advice or care from a licensed mental health practitioner") that frequently appear on such web pages. Instant intimacy and abandonment (e.g., communicating with an individual one day but finding that the e-mail address is no longer valid another day) may also end up as a topic of counseling (Weil, 1996).

The ethical issues associated with assessment on the Internet also have been debated and may be confusing to clients. Holmes (1997) noted the variety of free and fee-based psychological tests available and asked, "Is it ethical to just stick a test on the net and let people take it?" Similarly, Maheu (1997) sent the following message on WebPsych:

> I understand our APA ethics principles to require that our testee know what items of a question might mean, and they must also understand the test results. If people are offering tests online, how are they assuring that these and other related ethics principles are being addressed? (http://www.cmhc.com/mlists/webpsych/01519.html)

As both counselors and consumers take advantage of the Internet, there is no question that sharing information and resources via electronic mail (e-mail) will involve elements of counseling. Therefore, even if counselors are not promoting themselves as "Internet Counselors," they are not immune from issues related to Internet counseling. Consider the following scenarios:

- e-mail message to counselor: "There is an Internet support group for individuals with depression. I am thinking of joining; what do you think?"
- e-mail message to counselor: "I just finished reviewing the *Occupational Outlook Handbook* via the Internet. What do you think about me changing my major to...?"

If the counselor responds in any way other than "let's make an appointment and talk about it," it is likely that the counselor's response to either of these messages will contain elements of counseling. Does this mean counselors should avoid communicating with consumers via the Internet? No, but it does mean that counselors need to be cognizant of potential problem areas and address those problems before they arise. For example, consumers should be cautioned about what they put in writing (i.e., confidentiality) when nonsecure lines are used.

Counselors will need to weigh the benefits and limitations of recommending particular Internet sites. Figure 1 demonstrates some ben-

efits of topic-related chatrooms (e.g., empathy, support, provision of information) that individuals may obtain on the Internet. It is evident from the posted question that the individual is concerned about her son's friend and also concerned about her own son's well-being, per the reference to "contagious." In this case, the Internet allowed the mother to ask a sensitive question and receive some helpful information. Figure 1 also demonstrates some other benefits identified by Weil (1996): (a) immediacy (e.g., 24 hours a day every day); (b) a worldwide community, (c) a wealth of resources, (d) a cost-effective service, in terms of the cost of an on-line service, and (e) anonymity.

Figure 1. Sample e-mail exchange from the Meningitis Discussion Forum[1]

Posted Message: My friend's son has been hospitalized today. He left school with a severe headache....They say he is contagious. What's happening? Can you help me understand this? Thanks, Ginnie

Sample Reply: If the 16-year-old has bacterial meningitis, it is not contagious unless you have had direct contact with that person. If it is viral meningitis, then you should see your doctor right away. It won't hurt if you go to the doctor anyway if that would give you peace of mind. But, whatever you do, don't panic and don't become distant with the patient and family. I know from experience from when my two youngest children were stricken with meningococcal meningitis, many people panicked and acted as if anyone who knew my children were contagious. This made me very angry and upset. My biggest advice to you is to make sure you have all of the facts before you react. Most of all, if you are close with the family, give them all the support you can. Also, tell me how is the 16-year-old doing now? I would like for you to give the family my e-mail address....Maybe I can offer words of encouragement to the family, or maybe they may just want someone to talk to. Please let them know that I'm here for them if they ever feel the need to talk....

Carol

1. http: www/musa.org/_disc1/000000ef.htm

Some areas of potential concern that have been identified by the Ethics Committee of the American Psychological Association (APA) (1997) include: assessment, therapy, structuring the relationship, informed consent, and confidentiality. The Committee also noted the lack of nonverbal cues when using the Internet, the value of encryption to promote confidentiality, and potential legal issues related to possessing licensure in one state while counseling an individual in another state. Other ethical issues related to use of the Internet include record keeping, fee setting, credentials, advertising, and treatment planning (Stevens, 1997; Weil, 1996). To minimize their liability, some psychologists differentiate between "conducting therapy" and "offering guidance" in terms of their Internet services (Sleek, 1995).

Sampson, Kolodinsky- and Greeno (1997) summarized the benefits and limitations of the Internet as follows:

> (a) improve client access to counseling in remote areas; (b) improve client orientation to the counseling process, (c) facilitate completion of assessment instruments and homework assignments, (d) enhance record keeping and monitoring of client progress; (e) enhance counseling referrals, (f) expand access to assessments and support for test interpretation, (g) reduce scheduling complications in couples and family counseling; (h) encourage individuals to seek counseling via self-help resources; (i) increase options for supervision and case conferencing, and (j) enhance the collection of research data. However, without careful design, use, and evaluation, counseling services offered via the information highway may (a) limit the confidentiality of the counseling relationship; (b) deliver invalid information; (c) lack necessary counselor intervention; (d) be misused by inadequately trained or overworked counselors; (e) limit counselor awareness of important location-specific counseling variables; (f) restrict equality of access to counseling resources; (g) limit needed privacy for counseling; and (h) encourage service delivery by counselors without appropriate credentials. (p. 211)

There is a paucity of guidance related to ethical issues associated with the Internet. For example, APA (1997) has no rules prohibiting the use of the Internet and indicated that ethics complaints would be handled individually. The most definitive source to date is the "Standards for the Ethical Practice of WebCounseling, " developed by the National Board for Certified Counselors and reprinted in Figure 2.

Figure 2. Standards for the Ethical Practice of WebCounseling[1]

The relative newness of the use of the Internet for service and product delivery leaves authors of standards at a loss when beginning to create ethical practices on the Internet. This document, like all codes of conduct, will change as information and circumstances not yet foreseen evolve. However, each version of this code of ethics is the current best standard of conduct passed by the NBCC Board of Directors. As with any code, and especially with a code such as this, created for an evolving field of work, NBCC and CCE welcome comments and ideas for further discussion and inclusion.

Further, the development of these WebCounseling standards has been guided by the following principles:

- These standards are intended to address practices which are unique to WebCounseling and WebCounselors,
- These standards are not to duplicate non-Internet-based standards adopted in other codes of ethics,
- Recognizing that significant new technology emerges continuously, these standards should be reviewed frequently, WebCounseling ethics cases should be reviewed in light of delivery systems existing at the moment rather than at the time the standards were adopted.

WebCounselors who are not National Certified Counselors may indicate at their WebSite their adherence to these standards, but may not publish these standards in their entirety without written permission of the National Board for Certified Counselors.

The Practice of WebCounseling shall be defined as "the practice of professional counseling and information delivery that occurs when client(s) and counselor are in separate or remote locations and utilize electronic means to communicate over the Internet".

In addition to following the NBCC Code of Ethics pertaining to the practice of professional counseling, WebCounselors shall:

1. Review pertinent legal and ethical codes for possible violations emanating from the practice of WebCounseling and supervision.
   Liability insurance policies should also be reviewed to determine if the practice of WebCounseling is a covered activity. Local, state, provincial, and national statutes as well as the codes of professional membership organizations, professional certifying bodies and state or provincial licensing boards need to be reviewed. Also, as no definitive answers are known to questions pertaining to whether WebCounseling takes place in the WebCounselor's location or the WebClient's location, WebCounselors should consider carefully local customs regarding age of consent and child abuse reporting.
2. Inform WebClients of encryption methods being used to help insure the security of client/counselor/supervisor communications.

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Encryption methods should be used whenever possible. If encryption is not made available to clients, clients must be informed of the potential hazards of unsecured communication on the Internet. Hazards may include authorized or unauthorized monitoring of transmissions and/or records of WebCounseling sessions.

3. Inform clients if, how and how long session data are being preserve.
   Session data may include WebCounselor/WebClient e-mail, test results, audio/video session recordings, session notes, and counselor/supervisor communications. The likelihood of electronic sessions being preserved is greater because of the ease and decreased costs involved in recording. Thus, its potential use in supervision, research and legal proceedings increases.
4. In situations where it is difficult to verify the identity of WebCounselor or WebClient, take steps to address impostor concerns, such as by using code words, numbers, or graphics.
5. When parent/guardian consent is required to provide WebCounseling to minors, verify the identity of the consenting person.
6. Follow appropriate procedures regarding the release of information for sharing WebClient information with other electronic sources.
   Because of the relative ease with which e-mail messages can be forwarded to formal and casual referral sources, WebCounselors must work to insure the confidentiality of the WebCounseling relationship.
7. Carefully consider the extent of self disclosure presented to the WebClient and provide rationale for WebCounselor's level of disclosure.
   WebCounselors may wish to ensure that, minimally, the WebClient has the same data available about his/her service provider as would be available if the counseling were to take place face to face (i.e., possibly ethnicity, gender, etc.). Compelling reasons for limiting disclosure should be presented. WebCounselors will remember to protect themselves from unscrupulous users of the Internet by limiting potentially harmful disclosure about self and family.
8. Provide links to websites of all appropriate certification bodies and licensure boards to facilitate consumer protection.
9. Contact NBCC/CEE or the WebClient's state or provincial licensing board to obtain the name of at least one Counselor-On-Call within the WebClient's geographical region.
   WebCounselors who have contacted an individual to determine his or her willingness to serve as a Counselor-On-Call (either in person, over the phone or via e-mail) should also ensure that the WebClient is provided with Local crisis intervention hotline numbers, 911 and similar numbers in the event that the Counselor-On-Call is unavailable.
10. Discuss with their WebClients procedures for contacting the WebCounselor when he or she is off-line.
    This means explaining exactly how often e-mail messages are to be checked by the WebCounselor.

11. Mention at their websites those presenting problems they believe to be inappropriate for WebCounseling.
    While no conclusive research has been conducted to date, those topics might include: sexual abuse as a primary issue, violent relationships, eating disorders, and psychiatric disorders that involve distortions of reality.
12. Explain to clients the possibility of technology failure.
    The WebCounselor
    - *gives instructions to WebClients about calling if problems arise,*
    - *discusses the appropriateness of the client calling collect*
    - *when the call might be originating from around the world, mentions differences in time zones,*
    - *talks about dealing with response delays in sending and receiving e-mail messages*
13. Explain to clients how to cope with potential misunderstandings arising from the lack of visual cues from WebCounselor or WebClient.
    For example, suggesting the other person simply say, "Because I couldn't see your face or hear your tone of voice in your e-mail message, I'm not sure how to interpret that last message."

THE CHALLENGE OF DIVERSITY

Providing multiculturally-competent counseling is another challenge that likely will continue into the 21st century. Multiculture encompasses demographic factors such as gender, age, race, culture, social class, and sexual orientation. As Corey, Corey, and Callanan (1993) noted, failure to integrate multicultural knowledge, skills, and attitudes can result in misunderstandings between the counselor and client, which lessen the likelihood of establishing a counseling relationship, as well as infringe on the autonomy of the consumer. They stated that "imposing one's own vision of the world on clients not only leads to negative therapeutic outcomes but also constitutes unethical practice" (p. 265). It is likely that these misunderstandings have contributed to the underutilization and premature termination of counseling services by culturally diverse individuals (Schaller, Parker & Garcia, 1998).

Pedersen (1997) called for revision of the *American Counseling Association Code of Ethics* because of its "culturally biased perspective." Similarly rehabilitation professionals have called for changes in the *Code of Ethics for Professional Rehabilitation Counselors* (1988), because it provides little guidance for individuals who desire to be culturally

competent (Harley, Feist-Price & Alston, 1996; McGinn, Flowers & Rubin, 1994). McGinn et al. recommended that the phrase "regardless of race or ethnicity" be inserted in three of the canons and identified other terminology that they thought should be included in the rehabilitation counseling code. Although McGinn et al. interpreted multiculture more narrowly than others (e.g., Corey, Corey & Callanan, 1993; Harley, Feist-Price & Alston, 1996), it is likely that the counseling profession, as well as other helping professions (e.g., social work and psychology), will more fully address multicultural issues in future revisions to their codes of ethics.

Nonetheless, multiculturalism encompasses ethical issues related to the professional counselor's competence and adherence to all of the ethical principles (i.e., autonomy, beneficence, nonmaleficence, justice, and fidelity) that must be addressed by counselors. The Association for Multicultural Counseling and Development (Arredondo, 1998) recommended that the following competencies be considered along with the relevant Code of Ethics for counselors to avoid ethical violations; counselors must be:

> •Fully competent about oneself while recognizing all there is about one's personal history, orientation towards mental health and counseling, and experiences knowing and working with a pluralistic population;
> •Well-informed about the different clients' worldviews; and
> •Prepared with a wide-range of intervention skills and techniques that can be adapted to meet the individual needs and goals of respective clients. (p. 16)

Schaller, Parker, and Garcia (1998) suggested that counselors: (a) reassess their communication patterns (e.g., clarifying terms, providing better explanations related to why certain information is requested), (b) focus on process as well as outcomes, and (c) utilize the family in culturally sensitive assessments instead of focusing solely on the individual.

THE CHALLENGE OF CHOICE

Choice and informed choice will continue to challenge professional counselors, especially community, school, and rehabilitation counselors. Choice has been defined by Brigham (1979) as:

> the opportunity to make an uncoerced selection from two or more alternative events, consequences, or responses. By uncoerced, we mean that there are no programmed implicit or explicit consequences for selecting one alternative over the others except for the characteristics of the alternatives themselves. (p. 132)

As Bannerman, Sheldon, Sherman, and Harchik (1990) pointed out, choice is valued, even if it is only the perception of choice, since "many behavior analysts may argue that choice is not free" (p. 80).

Philosophically, choice always has been part of the counseling process; however, counselors will remain challenged in identifying methods of promoting choice and determining an individual's decision-making capabilities relative to choice. Issues related to choice involve the ethical principles of autonomy for the consumer and may include beneficence-nonmaleficence issues for the counselor, since choice is often compromised when counselors believe individuals (a) will make poor choices or (b) lack the skills or capacity to make choices.

The skill or capacity to make choices is generally linked with competence, a difficult counseling and legal construct. However, as Bannerman et al. (1990) pointed out, "people should be allowed to exercise as much choice as their abilities allow, whether it involves expressing a simple preference or weighing the advantages and disadvantages of several options during complex decision making" (p. 82). Powell (1984) indicated that "competence has practical utility as a concept only when we give it a context. A person may be competent to do one thing but not another.... We need always to be clear about the context in which we are assessing competence" (p. 58). Similarly, Beauchamp and Childress (1989) cautioned limiting autonomy only when there are true areas of incompetence.

THE CHALLENGE OF BALANCING: SETTING-SPECIFIC ISSUES

Another ethical challenge facing professional counselors is balancing employment outcomes and career development. With Welfare Reform measures (and most Workers' Compensation laws), employment outcomes are the goal, not career development. Simply stated, the focus is on "jobs" not "careers." This is not the case in some state-

federal programs, for example, where the costs of living with a disability often necessitate a career (and training to enter that career). The 1998 Rehabilitation Act Amendments identify the right of individuals to "pursue meaningful careers" [Section 2(3)(E)]. At the same time, the lack of any work experience may preclude individuals from anything but entry-level jobs. Unfortunately, most rehabilitation systems are not designed to assist consumers with career development issues; once consumers are employed for a specified period of time, their cases are closed. Thus, rehabilitation counselors will continue to be challenged with balancing employment outcomes and career development, based on the goals of their employment settings, while still adhering to Rule 2.9:

> Rehabilitation counselors will work with their clients in considering employment for clients in only jobs and circumstances that are consistent with the clients' overall abilities, vocational limitations, physical restrictions, general temperament, interest and aptitude patterns, social skills, education, general qualifications and other relevant characteristics and needs. Rehabilitation counselors will neither place nor participate in placing clients in positions that will result in damaging the interest and welfare of either clients or employers.

Another balancing act that ethically challenges professional counselors relates to balancing service, quantity, and cost. Although this issue affects counselors in all settings, it is particularly problematic in managed care environments. Kendrick (1998), for example, stated that "case managers working for the payer find themselves in the most complicated of balancing acts, often more so than independent case managers whose efforts are reserved only for the patient" (p. 19).

Managed care also has increased liability concerns of case managers. Wrinn (1998a) stated that "case managers have significant legal liability when it comes to their roles as decision makers. This liability crosses over all types of case management whether it be through a payer or provider" (p. 18), and cited the example of a case manager approving a treatment (once) when it was too late to be effective and the patient died. Legal and ethical concerns will continue to challenge counselors working as case managers in the managed care environment, where managed care entities and insurers frequently "dictate the appropriate modality and duration of treatment for clients" (Granello & Witmer, 1998, p. 373).

An example of a modality that also may challenge case managers is telemedicine or telehealth. Telemedicine/telehealth has been

defined as "accessing health care services using a medium besides hands-on, direct patient contact, including the use of telephone lines, computers, video hook-ups or similar technology," which includes "patient teaching and education, follow-up, medication monitoring, monitoring of cognitive and functional status, and mental health counseling" (Wrinn, 1998b, p. 18-19). The ethical issues previously identified with webcounseling likewise apply to telemedicine.

CONCLUDING COMMENTS

A number of ethical challenges have been identified that professional counselors will continue to address into the next millennium, including challenges related to technology, diversity, choice, and balancing. In contrast to the manner in which they were presented, counselors will not have the luxury of considering the ethical implications of these challenges in isolation, since they frequently are interrelated. For example, informed choice is complicated by multicultural issues (see Smart & Smart, 1997). Multicultural issues also are related to setting-specific issues, including forensic settings (see Havranek, 1997). Similarly, case managers have to address issues related to competence (Banja, 1993).

Perhaps one of the greatest challenges facing counselors in the next millennium will be maintaining their own professional competence. As Cottone and Tarvydas (1998) noted, "professional ethical issues are linked closely to general professional issues" (p. 3). However, ethical situations are not always addressed when general professional issues are discussed. Therefore, it is important for professional counselors to add this dimension to their continuing education. The skills of counselors, including their ethical skills (e.g., the ability to recognize ethical dilemmas and apply ethical decision-making approaches), "determine the quality of the profession" (Commission on Rehabilitation Counselor Certification, 1996, p. 1).

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Chapter 6

FUTURE TRENDS IN SELECTED SYSTEMS

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This chapter speculates on how counseling will change in selected systems through the first decade of the new millennium. Future trends in each system in which counseling is provided will be influenced by: (1) general changes in the structure and process of service delivery; (2) evaluation and accountability issues; (3) counseling populations; (4) funding mechanisms; and (5) counselor roles. First, however, this chapter will offer an overview of these trends and then examine in more detail some predictions for selected systems in which counseling services are offered.

GENERAL CHANGES IN SERVICE DELIVERY

Structural Changes

Increasing use of electronic media will move more counseling-related services out of traditional settings to internet and related applications. For example, web sites for occupational information and job placement assistance will continue to proliferate. Under such circumstances, more prospective "counseling" consumers are likely to meet their needs at computer terminals.

Similarly, more clients may find that the "virtual consulting room" (Stevens & Lundberg, 1998), i.e., counseling via the Internet, will meet their needs more conveniently and at lower cost than traditional counseling. Use of emerging technologies such as televideoconferencing will allow traditional counseling services to be provided to individuals and groups of clients at remote sites. In fact, although research is still

lacking, early data suggest that psychotherapy delivered by audio or televideoconferencing may be as effective as face-to-face interventions (Rabasca, 1998). More counseling-related services also will be offered in the workplace and in-home or elsewhere in the neighborhood, instead of in traditional agency settings.

As efficiency and cost needs dictate, changes will take place in organizational structures and the interfacing of individual service providers. This will provide easier and quicker access to services for consumers, which are factors associated with consumer satisfaction (Simon & Patrick, 1997). It also will reduce overlap among service providers and consolidate services for effectiveness and cost. For example, in the public sector, better interagency coordination, sharing of resources and partnerships with the private sector, will be required to meet political and legal mandates to provide more services with less resources. In the private for-profit and nonprofit sectors, partnering, brokering, and other alliances will bring together providers with the best demonstrated outcomes, as well as whose services can be most competitively marketed at low costs to payers.

Increased outsourcing of counseling services also will be used by public and private organizations to: (1) limit-long term staffing and benefits costs; (2) provide specialized sporadically needed services; (3) provide more responsive (e.g., timely) services during temporary periods of increasing workloads; and (4) provide more conveniently located services to consumers (including home visits). Outsourcing, when found to be more cost efficient, also will be used by government agencies to replace permanent direct service staff.

Process Changes

In response to demands for cost effectiveness, the counseling profession will intensify research efforts to identify the most efficient and effective counseling practices. The focus will be on better matching of client needs to appropriate services and attention to brief therapeutic methods (e.g., solution-oriented interventions). Utilization will increase for treatment modalities which deliver services to more than one person at a time, such as family therapy, group therapy, psychoeducational classes, bibliotherapy, and community support groups.

There will be movement away from models of individual pathology and treatment, toward health-strengths models (such as the solu-

tion-oriented approach). Furthermore, socio-cultural-environmental models that view contextual factors as important determinants of individual behavior and adjustment will become more popular. Such changes also should move counseling professionals into new areas of practice, such as family enrichment, workplace wellness programs, social advocacy, corporate and government consulting, and community empowerment programs.

For mental health services provided through managed care, the use of medications will increase. Drug therapies bring standardization of treatment protocols and predictability of costs to service delivery in a way that counseling has not been able to do. Although some data already suggest that psychotropic medications alone can be more costly and less effective than counseling ("Psychotherapy alone," 1996), counseling services, even when clearly the best alternative, may become less accessible to some clients treated under managed care.

Algorithms, clinical pathways and critical paths (Quigley, Smith, & Strugar, 1998) which provide standard protocols for treatment or other service provision, will be a useful mechanism for the counseling field to demonstrate the most cost effective methods for intervention. These approaches already are common in medical and rehabilitation settings and have potential applicability to other fields. Algorithms are likely to become more popular in counseling and related professions as research and practice in the long-term future clarify the best routes to successful outcomes. For example, in treating emotional illness, medication sometimes will be the treatment of choice. In most complex situations, however, combinations of modalities, often different at different phases of treatment and with involvement of interdisciplinary teams, will be deemed most appropriate.

Changes in Evaluation and Accountability

As in most human services, counseling organizations, programs, and providers will be more concerned with demonstrating measurable, socially, and politically meaningful results. These include: (1) consumer outcomes such as employment or retaining a job; (2) reduced need for government benefit payments; (3) improved health; (4) consumer satisfaction with the services, service context, and benefits received (service outcome); and (5) reasonable costs (Simon &

Macklin, 1999). The term "consumers" will include both the receivers of, and payers for, services. Counseling programs, organizations, and individual providers who cannot concretely demonstrate their value through cost, research and/or evaluation information, will not meet professional accreditation or legal requirements and will have difficulty competing for funding and customers. For example, as consumer pressure for quality increases, cost efficiency will become even more important for profit-oriented managed care organizations. This will likely lead to a "report card" approach to evaluating, employing, and retaining the best providers (English & Marino, 1998). Importantly, if counselors are able to demonstrate equal or better results at lower cost than traditionally utilized or higher paid professional specialists, this should ultimately create opportunities.

In the public sector, emanating in part from Vice President Gore's National Performance Review (1993), focus on value from a consumer and political perspective is gradually forcing all human service specialties, including counseling, to show meaningful results, or face reduction or extinction of funding. Finally, in the public, nonprofit and profit-making sectors, demonstration of meaningful results at less cost will be primary determiners for obtaining and retaining service contracts.

CHANGES IN COUNSELING POPULATIONS

Changes in demographics will impact the types of social and health care services needed. Counselors will be called upon to educate, intervene, and develop pertinent programs. They also will need to be more active advocates in the public policy arena to secure program funding. Among the fastest growing population segments are the over age 65 group and minority groups, particularly Hispanic Americans.

CHANGES IN FUNDING METHODS

Shifts in funding methods may draw more money to private sector counseling, i.e., private practitioners and groups, nonprofit and profit-

making organizations. As mentioned previously, for example, unless government programs can demonstrate better cost efficiency than private providers, more outsourcing will take place. In addition, as mental health counselors concretely demonstrate their effectiveness and cost benefits over other professionals, and as lobbying efforts increase, reimbursements from government sources (e.g., Medicare), private insurers, and managed care organizations will become the rule rather than the exception.

English and Marino (1998) reported that most (mental health) professional counselors currently work outside of managed care due to numerous roadblocks, ethical issues and administrative demands. However, this is likely to change as the managed care movement matures into a more viable service delivery system in which counselors can carve out a cost-effective preventive or curative niche. Other opportunities for private funding will include employer financing of workplace programs that demonstrate effective outcomes for organizations.

CHANGES IN COUNSELOR ROLES

In a competitive professional environment, it is expected that there will be heavy demand for future counselors to be experts in many roles. As generalists, nonetheless, they will need to be familiar with a wide variety of problems and populations and able to intervene from different theoretical systems.

Regardless of setting or role demands, counselors in the future will be among the most active advocates for clients. In a busy, demanding future, pressures to bend or weaken counseling's ethical standards will be greater than ever (R. Gillombardo, personal communication, November 11, 1998). Counselors will be major players within the service delivery system in understanding the ethical issues, being sensitive to the human needs of clients, and being in a position to safeguard and advocate for clients.

An important effect of the new millennium's multiplicity of demands, will be that counselors will probably experience increased job stress. Commensurately, high staff turnover may be common in many community settings. This also will add new roles, as counselors

fill in for missing positions, train new staff, and move up rapidly into supervisory and administrative positions. There will be an increasingly greater need for counselor education programs to prepare students and practicing professional counselors to meet these challenges.

CHANGES IN SELECTED SYSTEMS

Educational Systems

A trend toward developmental counseling in the schools (K-12) is likely to continue and proliferate into the next millennium. Impressive success for this comprehensive approach already has been demonstrated in terms of student growth and school climate (Lapan, Gysbers, & Yongmin, 1997).

Although three levels of school counseling have been identified, crisis, remedial, and developmental, schools traditionally have focused on crisis counseling for the troubled few. Developmental counseling seeks to serve all students by integrating the counseling agenda into the entire school curriculum, and collaborating with teachers to bring activities into the classroom. Such programs seek to help students successfully negotiate their developmental tasks at the appropriate times, thus precluding the need for later crisis counseling (Malley, J. C., personal communication, October 19, 1998). The recently published "National Standards for School Counseling Programs" (American School Counselor Association, 1997) include criteria to be met by school programs in three critical areas: academic development, career development, and personal/social development.

There are conflicting trends that will affect employment of school counselors at all levels in the new millennium. On the positive side, employment is expected to increase because of (1) increasing enrollments at the secondary and postsecondary levels, (2) state legislation requiring elementary school counselors, (3) greater need for counselor involvement in multicultural issues as diversity of student populations increases, (4) suicide prevention, (5) drug and alcohol problem solving, and (6) prevention/control of school violence (Bureau of Labor Statistics, 1998; Guerra, 1998). On the other hand, budget constraints, a possible trend to remove schools of counseling mandates, attempts

to provide more efficient services which may result in failure to hire counselors when they are needed, and use of other employees to assume traditional counseling functions (Guerra, 1998) may reduce the number of counselors needed. In some instances technology also may be used to replace school counselor functions. For example, at the postsecondary level the educational, vocational and job information functions of counselors may be increasingly replaced by advanced technologies that allow self-exploration and self-guided decision making.

Treatment and Rehabilitation Systems

These systems include organizations or programs (in which counseling plays a role) that contribute to treating illnesses, and to restoring physical and mental capacities. Significant systems in which change is expected include community mental health centers, substance abuse programs, HIV/AIDS programs, and head injury rehabilitation programs.

Community mental health centers (CMHCs), traditionally government funded providers of mental health services for average and low income persons, will see major shifts of clients to managed care programs. Some CMHCs have and will increasingly contract with managed care organizations to provide specialized services at lower costs than private providers (e.g., Medicare eligible chronically ill older persons). As competition for funding increases, CMHC's will compete to contract directly with employers to provide on-site mental health services, and to provide services to clients who have indemnity insurance or will pay fees themselves. Furthermore, employment for counselors in CMHC settings will be highly competitive with other mental health professionals (e.g., social workers, psychologists) who perform similar functions. Thus, it will be important for counselors to be able to differentiate the value and cost of their services to assure reimbursement or direct payment.

Substance abuse will likely continue as a major mental health problem in the United States. The good news is that recent outcome research supports treatment programs as being cost effective. This information has produced government proposals for increased block grant money to states to fund substance abuse treatment centers ("New

SAMHSA study," 1998). Although it is expected that increased funding will continue into the early 2000s, funding sources will be selective in the programs they support. There will be increased demand for identifying programs with clearly successful prevention and treatment methods. Specialty funding areas are likely to include elderly and teen populations, prescription abuse, in-school prevention programs, and substance abuse in the workplace. Counselors with special qualifications (e.g., national and state certifications), nonetheless, should have ample opportunities to work in substance abuse programs.

Counseling services for the HIV positive/AIDS population will continue to be a growing need. It is essential that counselors and other mental health professionals participate in program planning and administration (R. Gillombardo, personal communication, January 6, 1999) to insure that needed services are provided. For example, informed counseling staff must educate administrators about available mental health funding from sources not typically accessed by HIV/AIDS agencies.

Although medical advances have the potential to assist some persons who are HIV positive to have a higher quality of life, the public's misconception that there has been (or will soon be) a cure or that longer life is guaranteed, may contribute to an increase in denial regarding the dangers of HIV. Education and prevention programs may help, but the core issues that underlie high-risk behavior and denial must be addressed directly through counseling-related activities if programs are to succeed in halting the epidemic (R. Gillombardo, personal communication, January 6, 1999).

Counseling is becoming recognized as a major intervention for the medical sequelae resulting from head injury. In the document, "National Institutes of Health Consensus Development Conference Statement–Rehabilitation of Persons with Traumatic Brain Injury" (1998), counseling was listed along with cognitive-behavioral remediation, pharmacological management, and education in the currently used treatments for brain injury. By the early 2000s, it is expected that Certified Rehabilitation Counselors (CRCs), because of their unique training and experience, will become the primary case managers in hospital and interdisciplinary community rehabilitation programs for persons with head injuries (MacNeill, H., personal communication, November 9, 1998).

Vocational Rehabilitation and Job Adjustment Services Systems

These systems include agencies and programs that focus on career counseling, employment services, vocational rehabilitation, job training, and employee assistance program (EAP) services. In the future, the largest groups of recipients of such counseling services will include welfare participants entering or reentering the work force and adjusting to work, persons with disabilities receiving vocational rehabilitation services through public and private system providers, workers displaced due to a rapidly changing work force, and employees in the workplace. A major impetus for public and private financial support of counseling services will be economic, i.e., an expected reduction of government benefits payments, meeting new labor force needs, and employer needs for increased productivity.

In the vocational service areas, there likely will be intense pressure for counselors to produce greater quantities of expected outcomes. For example, public rehabilitation service programs have been criticized in recent years for achieving too few employed clients, with relation to the total clients served. Over time, such criticisms should lead to research initiatives that identify strategies and interventions (perhaps in the form of algorithms) that will result in more applicants continuing the process to successful completion. In addition, when public rehabilitation programs are unable to meet congressional expectations for outcomes, outsourcing of services to private providers increasingly will result.

In most job placement or return-to-work-oriented programs for persons with disabilities, e.g., state/federal and VA vocational rehabilitation, workers' compensation, and Social Security programs, there likely will be decreased emphasis on longer-term counseling, evaluation, training, and education, unless these can be demonstrated to clearly contribute to better and quicker employment outcomes. Instead, programs will focus on identifying transferable skills and providing short-term training, direct employment assistance, medical rehabilitation, and job adjustment services.

Counseling, information, and training services offered through a multitude of public-supported programs will be consolidated, with proliferation of one-stop centers per the Workforce Investment Act of 1998. This legislation also will provide enhanced training and related

services to dislocated workers and other adults (without income restrictions), as well as to disadvantaged youth. This will require counselors to develop skills to work integratively with professionals and support staff from a variety of agencies in co-located settings. Cost concerns and implementation of more high-tech information, self-evaluation and decision-making systems may reduce the need for counselors to provide some traditional services. However, there most likely will be an increasing need for job placement, case management, and job adjustment services that ensure that clients obtain and retain jobs.

Into the early 2000's, private counseling organizations and practitioners will be needed to provide job placement services for SSI and SSDI recipients, outsourced by the Social Security Administration (SSA) via contingency based contracts. Increasing case management services also may be needed for workers compensation claimants receiving rehabilitation services in preparation for reemployment. Insurance and managed care companies may be the largest users of such services.

Employee assistance programs (EAPs) also should see increased use, with integration of traditional referral services and other employer services, such as disability management, behavioral health care, financial and legal counseling, assistance with elder care and child care issues, counseling HIV positive employees, dependent care services, wellness and prevention services, employee coaching, violence prevention and debriefing, and stress management programs related to organizational change. In addition, increased drug and alcohol counseling, as a result of requirements of the Drug-Free Workplace Act (Oss & Clary, 1998), will be made available. Counselors also will play a role in advising employers on compliance with drug and disability related laws.

Case management will continue to be a central role for EAP counselors. Increasingly, EAP personnel will be challenged to prevent distressed employees from falling through the cracks that are growing between managed care services and community agency services. Fittingly, counselors who are certified EAP case managers (viz., Certified Employee Assistance Professionals [CEAPs]), will have the best future employment opportunities in such programs.

Provide Social Adjustment Services Systems

Systems that facilitate social adjustment presently include family service agencies, domestic violence programs, aging services, criminal justice programs, religious organizations, homeless programs, independent living centers, and immigrant programs. Within these systems, however, changes consistent with the needs of an aging population, attempts to manage crime, conflict, and violent behaviors, as well as movement toward greater spirituality as a supportive, curative medium, will play dominant future roles in counseling practice.

Trends toward a rapid increase in the elder population and an exponential explosion in medical advances, will open entirely new vistas of counseling needs. For example, "baby boomer elders" will likely demand opportunities to work at second or third careers, requiring vocational and career services through community agencies and private providers. Employee assistance programs will deal more with preretirement planning such as long-term care choices, health care planning, elder care counseling (for family caregivers), preparation for new social adjustments, financial planning and leisure options. In organizations that employ older second or third career workers, medical and behavioral health care, safety, cognitively focused retraining, and emotional/social adjustment issues requiring evaluation and counseling services, will emerge as productivity maintenance and enhancement become increasingly critical to employers.

Personal care, assisted living, and skilled nursing facilities, as well as new living options, are also likely to include counseling services for family and residents as part of service/care packages. Although public reimbursement of facilities for some of this counseling may be legislated (e.g., Medicare and Medicaid), most probably will be funded by residents and their families and be included in the total cost of care.

Services to reduce family violence, prevent new and recurring criminal behavior, and to assist victims of crime, likely will increase. Government-supported programs of this nature will require counselors to provide direct therapeutic intervention, prevention information, and training within the community. Needs for management of family problems, including marriage and divorce, also will continue to increase. New strategies for counselor practice in these and other expanded areas will include formal dispute mediation as a conflict resolution method (Hayes, 1997).

With greater social emphasis on "family values" and more public interest in spirituality, a trend is developing toward including the client's religious or other spiritual values as an integral part of counseling. Such approaches, which already have been part of drug, alcohol and related treatment programs, are likely to become more common as part of social and personal intervention in religious and nonreligious settings (Bart, 1998). This will require enhanced training within counselor education programs, as well as the building of new alliances among all religions and the counseling profession.

Systems that Provide Crisis Services

Counselors are gaining public and professional recognition as key helpers in disaster situations. Communities and disaster planning organizations increasingly will look to counseling organizations as a source of help in planning for disaster relief and in offering primary services in disaster areas. There also is a growing recognition that rescue and disaster workers can become secondary trauma victims requiring immediate counseling and debriefing services in field situations.

Excellent opportunities already are available for professional counselors to volunteer and receive specialized training in critical incidents stress debriefing (CISD) and crisis intervention for disaster work. For example, the American Counseling Association has begun collaboration with the American Red Cross to provide such training for counselors (Marino, 1998). More opportunities for training and for providing professional disaster counseling should become increasingly available in the next millennium.

Community crisis intervention agencies will continue to have an important role in emergency mental health services, including the prevention of suicide and violence. There also is a growing trend among crisis centers to function as umbrella agencies offering a broad range of crisis services, such as telephone hotlines for teens or shut-ins, traveler's aid bureaus at airports, transportation services for people with disabilities, and services to assist homeless persons. As counselors broaden their skill bases in these specialties, they become good choices for employment in these settings.

CONCLUDING COMMENTS

This chapter has discussed future trends in the counseling field generally and within the context of specific settings. It is evident that the future will bring great challenges as counselors come to terms with increasing demands for skills outside of the traditional definition of counseling, such as program evaluation, development, funding, administration, and advocacy. Counselors, programs, and agencies will have to be diligent in evaluating and documenting their successes so they can meet the demands for accountability and cost-effectiveness from funding sources. Commensurately, counselor education and supervision will be challenged to keep counselors flexible, up to date with changing technology and service delivery systems, and competitive with related professions.

As the growing need for mental health services exerts stress on institutions and service delivery systems, professional counselors will be challenged to bring a humanizing balance. Meeting such challenges successfully will take considerable courage and integrity, as well as a strong professional identity based on ethics and good science. Undoubtedly, counselors will find that their core skills will serve them well: to listen sensitively and respectfully, to discern core process dynamics, to collaborate and empower, and to adapt effectively to new and changing situations.

Looking to the more distant future, professional counselors and related specialists will need to constructively face the challenges of proactively transforming the human services delivery suprasystem. With cost issues of realistic concern and competition for funding and roles among overlapping professions such as counseling, psychology, psychiatry, and social work, a core of fewer, better differentiated professions and paraprofessions probably will emerge. This should eventually lead to a new, more efficient, cooperative, and effective human services "world order."

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Chapter 7

EMERGING POPULATIONS AND ISSUES IN THE NEXT MILLENNIUM

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Who will be the clients of the next millennium? What issues will cause them to seek the services of a professional counselor? Questions such as these will be explored as this chapter looks at the expansion of current client populations and forecasts the emergence of new populations and issues in the next millennium. Many of the projections are based on personal communications from professional counselors, psychologists, and social workers working in private practice and public organizations, as well as results from a survey administered to a segment of the Tampa Bay Association of Women Psycl otherapists, which consisted of 20 psychotherapists, both male and female, employed in private practice, and working with diverse clientele.

The questions we asked these professionals were: (1) "Which client populations/types of issues are you expecting to see more of in the next five to eight years?"; (2) "What treatment approaches will be utilized to assist in serving these populations?"; and (3) "What is your primary work setting and population served?". An analyses of the responses revealed several dominate populations (i.e., children, survivors of violence, the "sandwich generation" [aging baby boomers]), and the homeless. The predominate issues identified included violence (domestic, criminal, sexual), acting out and antisocial behaviors among children and adolescents, career/life transition concerns for aging adults, and depression and anxiety in general. In addition, a variety of other populations (single mothers, custodial fathers, same sex couples) and issues (divorce, substance abuse, and spirituality) also emerged. Many of the populations identified are not new, but rather

are expected to expand as the millennium approaches. It is beyond the scope of this chapter to discuss indepthly each of the populations or issues identified. However, several of the more predominate populations will be highlighted. These include: (1) children and related issues, (2) victims/survivors of violence and trauma, (3) the "Baby Boom generation", and (4) the homeless.

CHILDREN AND RELATED ISSUES

Lifestyles in the 1990s have been shaped by a variety of social demands which have resulted in numerous pejorative situations for many children. Such demands include, but are not limited to, work-related pressures, financial pressures, increases in cost of living, dual income families, and the physical and mental stressors associated with attempting to meet these demands. Furthermore, the decade of the 1990s has been marked as a period when a person's worth is measured by accomplishments and material acquisitions. Societal standards of success dictate that one demonstrate ownership of "things" (home, car, property, bank account) or achievement of recognition or fame in order to reach an acceptable level of status. Persons attempting to keep pace with these demands and those attempting to measure up to societal standards have paid a high price in terms of the amount of time and energy extended, and in the quality of their family relationships. As a result, more and more children are being left alone while both parents work, or are encountering parents who are too tired/stressed to spend a significant amount of quality time with them in the evenings.

During the mid to late 1980s, the term "latchkey kids" became synonymous with children who returned home from school to homes without adult supervision. As a result of the social demands placed on parents, the amount of time and quality of sharing between parents and children have suffered greatly. The fast paced–"go-go-go"–"hurry up and wait"–"do more with less–"gotta have it all" lifestyles of the 1990s have lead to a generation of children who rarely spend time with parents. Many family values which were evident in the 1980s (e.g., dinner together, weekend family time, perhaps church on Sunday) have virtually disappeared within many families. Instead,

they have been replaced with attitudes of "do your own thing"–"to each his/her own." For many children, peers have replaced parents, and television, computer games, and the Internet now consume more and more of their waking hours. As a result, many children are growing up with limited social skills and a reduced capacity to integrate successfully into mainstream society, obtain and/or maintain employment, and become productive citizens. Moreover, in a society that values material acquisitions and wants everything "yesterday," a growing number of children have turned to violence in order to acquire those "things" which they want, but are not willing to wait or work for. In 1996, Attorney General Janet Reno stated that youth violence is "the greatest single crime problem in American today" (cited in Heide, 1999, p. 5). It is projected that professional counselors will continue to see an increasing number of children/youth with limited social skill, antisocial behaviors, and aggressive and violent tendencies.

A closely related phenomena which warrants further discussion involves the growing number of children who will find themselves in the care of the state and in need of placement in foster care settings.

Kinship Care

Within the past 15 years, the number of children reported neglected or abused has increased by 333 percent (Hegar & Scannapieco, 1995). At the same time, the number of foster homes available for children needing out-of-home care has decreased by nearly 33 percent, from 147,000 in 1984 to 100,000 in 1990 (National Commission on Foster Family Care, 1991). One response to this has been an increased use of kinship care, defined as:

> The full-time nurturing and protection of children who must be separated from their parents by relatives, members of their tribes or clans, godparents, or other adults who have a kinship bond with a child. (Child Welfare League of America, 1994 [ref. in Hegar & Scannapieco, 1995], (p.201)

Kinship care can be both informal (wherein the family makes arrangements for the care of the child) or formal (where the state is the legal custodian and places the child in a family member's care). Most of the kinship caregivers are maternal grandmothers and aunts, with an average age of about 50 (Child Welfare League of America, 1994). The most frequently cited reason for kinship care placement is neglect and

substance abuse the average age of the children is seven or eight (Child Welfare League of America, 1994), and the largest percentage of them are African American (Berrick, Barth, & Needell, 1994). Since it is predicted that kinship care will continue to increase into the next century (Dubowitz, 1994), it is important that we understand the numerous issues related to kinship care.

Issues

Although the U.S. Supreme Court in 1979 ruled that foster kinship caregivers who met the standards for federal foster care were entitled to the same federal dollars as nonrelative foster caretakers, in reality fewer services are provided to these parents (Berrick & Barth, 1994). In addition, many kinship caregivers do not want involvement with federal or state governmental agencies such as welfare departments and the courts; thus, they do not become eligible for much of the funding. To add to the difficulties, inconsistent standards and services for relative caregivers exist even within states.

To qualify as a foster parent and to receive state benefits, caregivers often must have the child or children adjudicated as dependent by the court. Many kinship caregivers are resistant to scrutiny by government agencies, a well as resentful of formal home studies that must be completed as part of the process. The caregivers, who may very likely be a grandmother, could have been caring for her grandchildren for several years and may resent an outside agency performing a home study to determine whether or not she qualifies as a suitable formal foster caregiver for these children. For example, she may be told that she can no longer place three children in one bedroom since this may violate agency standards. For these reasons, many kinship caregivers do not apply for support from the state. However, caregivers' need for support is often very great: "relative caregivers, however, are generally older and less financially stable than other foster parents, and require greater financial and social service support" (Berrick et al., 1994, p. 7). The caregivers also may feel that they need to legally adopt the grandchildren because of the risk of losing the grandchildren when the parents reappear and want them back, even if the grandparents do not believe this decision is best for the children. Having to give up the grandchildren after several years of caring for them can be very painful:

> Your life will be turned upside down yet again. You had traveled the road from grandparent to parent; reorganized your life around these children; and loved and nurtured them for months, if not years, and now you will be expected to give them back like any part-time baby-sitter. (Toldeo & Brown, 1995, pp. 134-135)

Toledo and Brown (1995) described some of the other difficulties grandparents who become caretakers often experience. These include: (l) changes in work life, such as needing to give up retirement or changing shifts at work to be able to care for the grandchildren; (2) changing one's routine such as needing to get up early to get the grandchildren off to school; (3) eliminating or decreasing one's social life because of the focus on grandchildren; and (4) the ending of future dreams so to focus on the grandchildren (pp. 24-27). These grandparents easily can become physically, emotionally, and financially exhausted.

The children who must leave their nuclear families to live with a relative also often suffer a great deal. They may feel abandoned by their parents and confused about to whom they should feel loyal: parents or grandparents. Some children feel responsible for their parents' problems and carry guilt with them about the breakup of their home. Sometimes these children feel embarrassed to be living with their grandparent, and ashamed to bring friends home. The children may have nightmares, temper tantrums, periods of crying and clinging, difficulty concentrating at school, conflicts with caretakers and peers, and substance abuse when older.

Many of the parents who give or release their children to the grandparents for caretaking do so because of substance abuse problems. These individuals are sometimes incarcerated for substance-related crimes and then return to claim their children after release. As is the case with substance abuse, these parents often relapse after a time and then again must give their children to the grandparents, either voluntarily or involuntarily. The parents may experience a great deal of guilt about their inability to care for their own children and may project anger at their parents for doing a better job at parenting than they are.

It is important to note that there can be advantages to kinship care over traditional foster care. Children in kinship care placements are more likely to maintain contact with their parents, siblings are more likely to be placed together, and the child's racial/ethnic identity is

more likely to be maintained (Berrick et al., 1994). In addition, "kinship care is one of the best forms of family preservation" (Danzy & Jackson, 1997, p. 34).

Current Treatment Approaches

As mentioned above, the federal government, as well as many states, has initiated specific legislation to meet the needs of kinship caretakers. However, there are many obstacles to the legislation actually helping the caretakers. In addition to the resistance many grandparents feel about government involvement in their lives, the governmental programs and policies are often confusing and inconsistent. For example, Gleeson and Craig's (1994) study of states' policies about kinship care found: "a lack of clarity, a lack of consistency across states and value conflicts regarding policies guiding placement of children with their relatives" (p. 7).

In an effort to assist caretakers in understanding relevant legislation, and to increase their knowledge of community resources, some cities and states have created kinship care resource books. These can be extremely useful to caretakers in helping them understand legal issues and become aware of services that may be available to them.

Support groups have been established in many states across the nation. The original support group for kinship caretakers was started by Celestine Brown in Oakland, California in 1979, named *Grandparents as Second Parents.* This group provided an opportunity for grandparents and other kinship caretakers to express their sadness, anger, frustration, guilt, and also joy at raising the children they had been given. The group members offered solace to each other, as well as practical advice on how to handle issues relating to the children, the adult parents, the welfare department, legal difficulties, and financial concerns. Experts were invited to provide helpful information on coping with "the system," and to provide information about resources in the community. Now there are caretaker support groups in most large cities and towns in the United States. Another intervention originated by Celestine Brown that has been replicated in some locations is the creation of a "warm line:" a 24-hour-a-day answering service for any kinship caretaker to call when she or he needs support and a kind listener.

Workshops for grandparents and other caretakers, as well as for professionals, are now held in many cities. These workshops usually provide an opportunity for caretakers to express their frustrations and other feelings, and then work together to plan ways to increase their support systems and knowledge bases about resources. In addition, these workshops often provide an opportunity for grandparents to make political plans to pressure their legislature for increased funding and services for kinship care.

Implications for Professional Counselors

First, professional counselors need to expand their definition of "family" to include kinship networks. Mental health professionals need to be educated about the difficulties and strengths in kinship care families and be trained to perform assessments and formulate treatment goals for these family constellations. Rittner (1995) recommended shifting our focus from making decisions for kinship care families to making decision with them.

Wilhelmus (1998) recommended that mental health professionals increase their skills in mediation. Mediation may be necessary to assist in settling conflicts between the kinship care family and the welfare department or judicial system. Mediation may be especially necessary because of the power differentials between the families and public agencies. Professionals can help families by translating legal jargon into understandable language, helping caretakers conceptualize and organize their concerns and needs, and stating the needs in as effective a way as possible.

In addition, professional counselors need to advocate for their kinship care clients' needs. Helpers must continually put pressure on policy makers to increase funding and services to kinship care families. They should meet with legislators, explaining the issues and concerns of this often ignored but growing population.

VICTIMS/SURVIVORS OF VIOLENCE AND TRAUMA

"The Age of Rage" is a phrase that is commonly used to describe the latter half of the 1990s. We are bombarded daily with images of

violence in homes, schools, and communities across the United States. It appears that people are simmering and seething inside. In 1996, U.S. residents age 12 or older experienced approximately 36.8 million crimes (Bureau of Justice Statistics, 1998). Of this number, 74 percent (27 million) were property crimes, 24 percent (9.1 million) were crimes of violence and 1 percent were personal thefts. Moreover, in 1996 for every 1,000 persons age 12 or older, there occurred one rape or sexual assault, two assaults with serious injury, and five robberies. Murder was the least frequent violent crime, with about seven murder victims per 100,000 persons in 1996. However, among American youth such is not the case.

While violent crimes committed by adults are declining, it has been rising significantly among the nation's young people (Heide, 1999). The percentage of all homicide arrests involving juveniles more than doubled from 7.3 percent in 1984 to 15.0 percent in 1996. Analyses of crime patterns clearly indicated that youth are killing in record numbers in the United States as we approach the new millennium (Solomon et al., 1990). Experts have projected that if murders by youth continue to grow at the current pace, juvenile arrests for homicide will number 8,100 by the year 2010, an increase of 145 percent in less than 20 years (Snyder & Sickmund, 1995).

Victims of trauma associated with natural disasters (e.g., fires, flooding, hurricanes, tornadoes) are on the increase as well. In an interview which aired on the MacNeil/Lehrer News Hour (December, 1998), Janet Abramovitz, senior researcher at the World Watch Institute, reported that "1998 was a record setting year for economic losses from weather-related disasters. Storms, floods, fires, and droughts caused at least 89 billion dollars in damage worldwide this year"..."that exceeds the total for the entire decades of the 1980s." During the same interview, Mr. John Clizbi, Executive Director of the American Red Cross stated that "1998 was easily our most demanding and literally our most expensive year in our 117-year history." According to researchers, the earth's atmosphere is heating up and, consequently, there is increased likelihood that we will continue to see more natural disasters. If researchers are accurate in their predictions, increased natural disasters will have significant global ramifications as we transition into the next millennium. This phenomena also will present considerable challenges to those professionals trained to assist

trauma survivors (e.g., police, emergency medical personnel, rescue worker, professional counselors). These folks are exposed and consequently, at-risk of adding to the growing number of traumatized persons; a phenomena known as vicarious traumatization (McCann & Pearlman, 1990).

Issues and Treatment Approaches

Trauma disorders, domestic violence, and school-related violence were identified by our survey respondents as issues which are projected to impact professional counselors in the next millennium.

TRAUMA DISORDERS. The term posttraumatic stress disorder (PTSD) is commonly applied to people traumatized by one of many types of traumatic events. These events are outside the range of usual human experiences and would be markedly distressing to almost anyone. Events which present a serious threat to self or that bring about sudden destruction of one's environment are considered traumatic. Examples of trauma may include but are not limited to "criminal victimization (e.g., sexual battery, domestic violence, homicide of a family member); the suicide of a family member or friend; a natural disaster (e.g., earthquake, hurricane); accidents; combat; and social violence (e.g., riots, political terrorism)" (Dutton & Rubinstein, cited in Figley, 1995, pp. 83-84).

Traumatization can occur directly or indirectly (simply by learning about traumatic events). Secondary traumatic stress (STS) is defined as "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experience by a significant other–the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1993, p. 7). STS, also known as vicarious traumatization or compassion fatigue, can be seen in persons who work directly with or have direct exposure to those that have been traumatized and can include mental health professionals, victim advocates, physicians, rescue workers, and the like.

A central issue in the management of trauma is the provision and restoration of social supports, such as family, friends, and colleagues. These supports provide a source of protection against traumatization. Cognitive-behavioral therapy, eye movement desensitization and reprocessing, pharmacotherapy, hypnosis, group psychotherapy, and

a technique called "testimony" are commonly used in the treatment of PTSD (Van der Kolk, McFarlane, & Weisaeth, 1996). Current methods utilized in the treatment of STS can be grouped into three categories (i.e., personal, professional, and organizational) and range in strategies from the maintenance of a personal life and use of personal psychotherapy in the personal category, to development of professional connections and a balanced work life in the professional category, to attending to the physical setting (i.e., safe working environment) and arranging for adequate resources (e.g., regular supervision, consultation, case review) at the organizational level (Pearlman & Saavitne, cited in Figley, 1995).

DOMESTIC VIOLENCE. Violence against women and children is an epidemic in American society and is the leading single cause of injury to women in the United States. Every 12 seconds, a woman is beaten by her partner. Domestic violence affects every member in our society through its long-term impact on exposed children. According to a 1993 study by the Harvard School of Public Health, " a child's exposure to abusive adult relationships often causes low self-esteem, depression, and anxiety in girls, and aggression and behavioral problems in both boys and girls" (cited in Women's Work [brochure]). Battering is a learned behavior and consequently, violence in the home tends to perpetuate violence in the streets. Children from violent homes are 74 percent more likely to commit assault and male children from violent homes also are more likely to become abusive adults.

Treatment approaches for domestic violence survivors resemble those used in the treatment of PTSD. Of paramount importance is the provision of a safe environment for the woman and her children. Adequate medical attention also is often necessary. Other forms of treatment include individual and group counseling and psychoeducational and support groups designed to teach women and children (1) to recognize signs of violence, (2) to protect themselves, (3) how and where to seek help (legal and otherwise), and the like. Many programs also offer some groups and psychoeducational programming for batterers. The growth in programs and shelters for survivors of domestic violence have served to provide "safe houses" for countless women and children throughout the U.S. and increased their likelihood of survival. If the cycle of violence is to be arrested, "society must com-

mit to programs, funding, and legislation dedicated to addressing this epidemic so that victims will be heard, supported, and helped and batterers will learn that violence will not be tolerated" (*Women's Work* [brochure]).

SCHOOL VIOLENCE. One of the most troubling aspects of youth violence has been the increase in school-related violence. The 1997-1998 school year served as a wake-up call to the facts that (1) not all students who carry guns are members of gangs or inner-city ethnic youths, (2) white children from middle American do bring guns to school, and (3) some students will use them to kill. Communities across the U.S. (Alaska, Oregon, Tennessee, Kentucky, Mississippi, Pennsylvania) have been forced to face the fact that violence can happen to them. "After the tragic loss of life and injuries at Thurston High School in Springfield, Oregon, President Clinton directed the Department of Education and the Department of Justice to develop an early warning guide to help adults and school personnel identify and reach out to troubled children quickly and effectively" (Attorney General Janet Reno, cited in U.S. Department of Education, 1998, p. i). Early warning signs identified in this guide include (1) social withdrawal; (2) excessive feelings of isolation and being alone; (3) excessive feelings of rejection; (4) being a victim of violence; (5) feelings of being picked on and persecuted; (6) low school interest and poor academic performance; (7) expression of violence in writings and drawings; (8) uncontrolled anger; (9) patterns of impulsive and chronic hitting, intimidating, and bullying behaviors; (10) history of discipline problems; (11) past history of violent and aggressive behavior; (12) intolerance for differences and prejudicial attitudes; (13) drug and alcohol use; (14) affiliation with gangs; (15) inappropriate access to, possession of, and use of firearms; and (16) serious threats of violence.

Education of parents and school personnel regarding the above warning signs are the first steps in prevention and early intervention. Students displaying the above warning signs should have access to trained professional counselors (i.e., school counselors and psychologist, mental health counselors). Efforts must also be taken to ensure that these students are placed in appropriate classrooms. The warning guide recommends that violence prevention response plans include the following principles: (1) share responsibility by establishing partnerships with the child, school, home, and community; (2) inform par-

ents and listen to them when early warning signs are observed; (3) maintain confidentiality and parents' rights to privacy; (4) develop the capacity of staff, student, and families to intervene; (5) support students in being responsible for their actions; and (6) simplify staff request for urgent assistance. Inclusion of these principles into a violence prevention response plan would enhance the likelihood that schools and communities are better prepared to handle incidents of school-related violence.

Implications for Professional Counselors

The likelihood of experiencing violence or a traumatic event is an every present threat which affects all segments of American society. As such, professional counselors must be ready to respond with appropriate strategies and interventions. Maintenance of knowledge and skills in crisis intervention, cognitive behavioral approaches, and other innovations in trauma treatment all will be necessary in addressing the needs of persons surviving violence and trauma, including children. Professional counselors must take every precaution to guard against vicarious traumatization through the maintenance of adequate support systems, attending to personal safety concerns, and the development of nonwork-related activities. Furthermore, professional counselors also will need to possess, or be willing to acquire, an awareness, knowledge, and skills to effectively respond to the need of diverse cultures (within the U.S. and abroad).

THE SANDWICH GENERATION

Baby boomers, persons born in the United States between 1946 and 1964, number approximately 76 million and constitute one of the most educated and publicized generations in the country. When the Baby Boom generation is fully retired in the year 2030, there will be 70 million Americans over the age of 65 (National Association of Area Agencies on Aging [NAAAA], 1999). The 85+ population is projected to increase from 3.9 million to 8.5 million in 2030 and the population of racial and ethnic minority elderly is projected to represent 25

percent of the elderly population. For example,

> Hispanic elderly will increase more than sevenfold between 1990 and 2050. Concurrently, African American elderly will more than double during the same period. A disproportionate number of ethnic and racial minorities will enter advanced age with fewer financial resources to provide for their needs. (NAAAA, 1999, p.1)

Issues

One problem currently facing baby boomers at midlife is the simultaneous responsibility of caring for both children and aging parents. This phenomena has been the impetus for the term "the sandwich generation," and has placed substantial emotional and physical strain on those persons attempting to meet these dual responsibilities. There also is a heavy financial burden bought on by the high cost of medical care, long-term residential care, and loss time from work. In response to this growing phenomena, the White House unveiled a proposal for long-term care to support family caregivers and to help address growing long-term care needs. If passed, this proposal would provide a range of critical services for caregivers such as respite, home care services, and information and referral, and would be authorized through the Older American's Act (Administration on Aging [AoA], 1999).

A second issue which will have a major impact, not only on the Baby Boom generation, but on society as a whole, involves the financial realities as these 76 million persons began to retire. Many are facing retirement with financial uncertainty. The National Center for Women and Retirement Research conducted a study of 1,140 women and men between the ages of 45 and 60. According to their findings, 70 percent of the baby boomers reported that they are worried and pessimistic about their financial futures. Two-thirds of the respondents reported having less than $50,000 in their 401(k) or 403(b) plans, and 20 percent had accumulated less than $10,000. The median assets in their accounts was $35,000. "The retirement prospects for millions of our still productive citizens are among the most threatening social and economic problems of the approaching millennium" (Hayes, 1999, p. 2).

The major source of income for older individuals in 1997 was

Social Security (reported by 91% of older persons), income from assets (63%), public and private pensions (41%), earnings (21%), and public assistance (6%) (AoA, 1999). About 3.4 million older persons live below the poverty level in 1997. "The sheer size and composition of this generation of retirees place unprecedented challenges on the Medicaid, Medicare and Social Security programs" (NAAAA, 1999, p. 1). The fact that many of these persons were not employed in jobs with pensions plans, coupled with insufficient or no retirement planning, and longer life expectancies, will only add to the financial and economic burden facing the U.S. in the next millennium. Furthermore, "some estimates reflect that by 2040, nearly 14 million Americans will need some form of long-term care assistance, including about 10 million who will need home and community-based care" (NAAAA, 1999, p. 1).

Third, many boomers married later than their parents, and a larger number have remained single. They are less likely to be living in married-family households or with their parents, and more likely to be living alone, as single heads of household, or with a partner to whom they are not married. Additionally, they have had relatively few children, sparking concern that those who may need care or assistance in advanced age will have a small circle of immediate family to draw upon (AoA, 1999), a concern that is likely to add to the already escalating problem of abuse among the elderly.

Implications for Professional Counselors

It is projected that boomers in later life will be disproportionately women, single, and on average, have fewer children. Also, according to new finding from the National Long Term Care Surveys (cited in National Institute on Health, 1999), disability among older persons in the U.S. is decreasing. Consequently, a wide array of opportunities are emerging for professional counselors providing services to the baby boom generation. For example, employment beyond retirement age will be a common practice for many baby boomers. For some, continued employment will be a necessity of survival. For others, employment will be desired as their health status is expected to be above average. Professional counselors also will be needed to provide a wide variety of services including (1) career transition planning, (2)

traditional and alternative therapies, and (3) advocacy and policy development. Among more affluent boomers, assistance will be needed in the areas of specialized long-term and in-home health and financial planning to name a few. Because a significant percentage (25%) of aging baby boomers are projected to be ethnic minorities (NAAAA, 1999), it is imperative that professional counselors be prepared to deliver culturally sensitive and appropriate services.

THE HOMELESS

Homelessness continues to be a complex problem in today's society. Maintenance of permanent housing would appear to be the answer to alleviating homelessness. However, there are other aspects of homelessness that must be addressed before permanent solutions can be implemented. Homelessness is defined as a lack of any type of a regular dwelling (*Encyclopedia of Social Work*) and can be further subdivided into three groups: (1) *chronic*–without shelter for long periods of time. Many communities further define chronic homelessness as any person who has been without permanent shelter for six months or more, (2) *episodic*–cycling in and out of homelessness due to various reasons including personal stressors or major financial upheavals, and (3) *situational*–without housing for a few nights due to a variety of causes. In addition, there are also the "hidden homeless" who double up with relatives or sleep in abandoned cars or buildings and do not show up on any census reports (Edwards, 1995).

According to the U. S. Department of Housing and Urban Development (1998), the homeless are those individuals with economic problems (such as unemployment or underemployment), the chronically disabled (including substance abusers and mentally ill), or those in personal crises (divorce, domestic violence, or health problems) (Morales & Schaeffer, 1998).

Studies of the homeless report far greater diversity than in previous decades. For example, homeless families, typically in severe economic circumstances, are one of the fastest growing segments of the homeless population (Garvin & Tropman, 1998). The majority of families now living in shelters consist of young, single mothers with one or two children under age six, who have spent their lives exposed to a

cycle of family and community violence, and poverty. Due to limited education, many of these mothers lack the skills to obtain employment which provides income sufficient to sustain a family. In some cases, these families once had homes but were not able to keep them.

Homeless children often grow up cut off from the educational opportunities which can eventually lead them out of poverty because they are often victims of interrupted or nonexistent education. Consequently, they are frequently subjected to the same web of poverty and violence that plagued their parents. Also, many of these children lack the ability to establish normal relationships. This difficulty in forming relationships is often compounded by the fact that homeless children miss school frequently and fall behind. Runaways and throwaways (teenagers thrown out of their homes by parents) are often forced to live marginally as they are not accepted in adult shelters nor do they have easy access to food. They are fearful of being returned to abusive or unsatisfactory homes and often go underground. Such lifestyles exposes them to abuse, victimization, pregnancy, and sexually transmitted diseases.

Lastly, there is a growing population of elderly (age 60 or older) homeless individuals. Presently, approximately 27 percent of all homeless individuals are elderly. Of this number, more than 50 percent suffer from chronic mental illness, poverty, and a lack of affordable housing (National Coalition for the Homeless [NCH], 1998).

Issues and Treatment Approaches

One of the most obvious factors contributing to homelessness is the inability to make payments for shelter. This is due to the incapacity of the homeless to earn consistent income in order to make steady rent payments. Many homeless are classified as the "working poor" or "underemployed" and often in jobs that pay the minimum or below minimum wage, and are frequently employed in a sporadic manner such as day labor or in part-time or contractual services without benefits or job security.

A second factor involves recent legislative mandates. During the past several decades, public assistance has been an alternative means to pay the amount needed for rent during times of poor employment. New welfare reform regulations limit the length of time on welfare

rolls as well as eligibility. There are time limits on benefits in the new Temporary Assistance for Needy Families, federal funding for general assistance is eliminated, and SSI denies payment to legal and undocumented immigrants. Fewer people will receive benefits as a result of these changes. Employment does not necessarily lead to self sufficiency, and economic status remains marginal when wages are marginal. The availability of jobs is presumed in the new welfare regulations and the impact of a high unemployment rate combined with these new regulations has not been thoroughly studied.

A third factor involves inadequate housing assistance programs and an insufficient number of affordable housing units. In the 20-year period between 1973 and 1993, while 2.2 million low rent units disappeared from the market, there was a 4.7 million increase in low income renters (Salvation Army Statistics, 1998). Renters seeking low rent housing are faced with substandard housing, overcrowding, and a disproportion of their income going toward rent. HUD statistics indicate that the supply of low cost housing decreased between 1993 and 1995 by 9000,000, units or roughly 10 percent of the overall supply and that 5.3 million unassisted, very low income households had worse case needs for housing assistance in 1995 (U.S. Dept of Housing & Urban Development, 1998). Housing Assistance programs show lengthy waiting lists for Public and Section 8 Housing (NCH Fact Sheet #1, May 1998).

Implications for Professional Counselors

The purpose of providing services and resources to the homeless is to meet the immediate life needs of homeless persons, to encourage stability, and to assist them in gaining independent functioning (Hillsborough County Homeless Coalition, 1998). Methods to achieve these goals include: (1) *outreach* (reaching into the community to establish trusting relationships that will lead individuals into services), (2) *an effective intake and assessment process* that works with comprehensive case management, and (3) *linkages to services*. These steps are critical to connecting the homeless to support services including mental health, health, educational, vocational, and child care services that work together with referrals to emergency shelters and the transitional, subsidized, permanent, and market rate housing services.

Increased case management services, transitional housing and counseling programs, support for victims of domestic violence, relocation assistance, and services for disabled family members also must be taken into account when developing counseling programs for the homeless. Other areas to included are dropout prevention and remediation for teenage parents, counseling to improve capacity for long-term employment, mental health and substance abuse treatment, and job retention skills. Families may well be the fastest growing segment of the people who are homeless, constituting about 40 percent of those who become homeless. They often live with relatives or friends for short periods of time, move to shelters, and then move again. Innovative programs must be developed to address the root causes, as well as the personal impact of homelessness.

Thus, professional counselors must be prepared to provide multi-faceted services that include life sustaining services, rehabilitative services, and policy and program advocacy, empowerment efforts in order to counteract the effects of oppression, alienation, and hopelessness (DuBois & Miley, 1999, p. 307-309).

OTHER EMERGING POPULATIONS AND ISSUES

Technological and medical advances will likely contribute to a growth in genetic counseling.

> As individuals gain the ability to identify whether or not they carry a gene for a disorder, a number of issues will be raised. Individuals will struggle with whether they should be tested for the disease, how they should live out their lives if the gene is present, whether or not they should have children...and whether they should share...the knowledge that they carry the gene for the disease." (Neukrug, 1999, p. 475)

Professional counselors must be ready to assist with such questions and well as face the associated ethical dilemmas. A similar growth in cloning research and counseling may be witnessed.

Professional counselors are likely to see an increase in nontraditional (same sex) couples with issues ranging from marriage and adoption to traditional couple concerns. Changes in family composition over the past two decades have altered relationships between fathers and children. More fathers are choosing to stay at home and care for

the children while the mother works. Also, fathers have gained ground in securing custody of their children. Many men are struggling with traditional ideals of malehood versus a growing appreciation and acceptance of men who are willing to show feelings. As a result of these and similar changes in our society, it is projected that professional counselors will see an increase in the number of men seeking counseling. As the millennium approaches end-time prophecies are projected to escalate. There is a tendency for large numbers of people to turn to religion and seek spiritual guidance, consequently, an increase in spiritual counseling is expected.

In many Eastern countries, the belief in a mind-body connection always has been accepted. In the U.S., however, acceptance of this connection has not come without question. Now that researchers are showing a connection between how we think and the impact of those thoughts on our physical state, professional counselors may witness a growth in clients seeking alternatives to traditional psychotherapy and will need to be familiar with the mind-body connection. Again, the need for diversification and flexibility in treatment approaches can not be understated.

Finally, a variety of factors will impact the selection of treatment modalities in the new millennium, including managed care, privatization (see Chapter 2), and credentialing requirements. Brief therapy, solution focused therapies, and group counseling have proven to be both cost effective and therapeutically valuable, and will continue to be used widely. It is projected that the use of psychotropic medications also will increase as we move into the next millennium. This increased utilization has an economic and social basis. In terms of economics, the cost of prescribing medication is less costly and may be more effective in terms of immediacy of improvement than more traditional psychotherapy. It also addresses our society's desire for "quick fixes" (Dr. Gary Dudell, personal communication, November 16, 1998).

There is a growing trend toward the inclusion of psychoeducational methods in counseling interventions. The use of psychoeducational methods represents a return to primary intervention strategies which are aimed at the prevention and early intervention of problems before inappropriate behaviors occur. According to Dr. Joe Ferrandino (personal communication, November 16, 1998), "psychoeducational workshops will be used increasingly in the new millennium to address such

issues as teaching pro-social skills among youth, parenting skills among adults, and the like."

CONCLUDING COMMENTS

Client populations and issues in the new millennium have emerged as a by-product of our society. It easily can be said that changes in one affect changes in the other. Many of the populations that professional counselors will encounter in the new millennium will be unchanged, while others will come as a result of current medical, technological, and sociopolitical realities. Already, medical advances are impacting the clientele of professional counselors in ways previously unimagined (i.e., genetic and cloning therapies). Technology will continue to shape the ways in which professional counselors do their jobs. For example, technological advances have catapulted the counseling profession into a global community, with unlimited opportunities to reach out and touch people virtually anywhere in the world. Such an open door to the world brings with it a tremendous ethical responsibility to cultural competence which encompasses the need to provide culturally sensitive and appropriate services, and to possess relevant culture specific knowledge. Sociopolitical realities have combined to impact families, children, and communities in significant ways. Additionally, the economic realities of managed care, accountability, and privitization now require professional counselors to document the effectiveness of the services provided. Consequently, research is desperately needed for the development of evaluation tools which will validly measure the difficult-to-measure psychodynamic treatments used by many professional counselors.

The projections outline herein suggest that the future of professional counselors appears bright even though it is changing. Flexibility, creativity, and continued education will position professional counselors to transition effectively into the next millennium.

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Chapter 8

DIVERSITY WATCH FOR THE NEW MILLENNIUM: REVERSING THE TIDE OF EXCLUSION

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Concern over diversity is increasing. Importantly, this concern not only test the strength of our society's social fabric, but it also is becoming increasingly central to professional counselors and other human service professional's ability to provide efficient and meaningful services. A precursor in preparing to meet the opportunities of diversity in the new millennium, is the need to become familiar with specific cultural concepts. These concepts are important to our understanding because one's culture is central rather than marginal to the theory and practice of counseling (Pedersen, 1997). Therefore, it is important to address those cultural concepts that are central to the history of understanding culture in America. We begin by clarifying or defining the following: *affirmative action, cultural diversity, multiculturalism, cross-cultural counseling,* and *multicultural counseling competency.* We then take the reader into a brief overview of some historical underpinnings necessary for understanding culture in America, taking care to discuss the impact of these historical precedents on the counseling profession both now and in the future. Following this discussion, we share with the reader demographic trends in higher education and briefly discuss these trends in light of their impact on professional counselors in the next millennium.

CONCEPTUAL PRECURSORS TO MANAGING DIVERSITY IN THE NEW MILLENNIUM

AFFIRMATIVE ACTION is a social justice effort driven by the U.S. government, as mandated by the 1964 Civil Rights Act. It began as a response to the failure of civilian businesses with government contracts to hire women, persons with disabilities, and minorities (Jackson, 1994). Historically, affirmative action has been the major strategy effectively used by the federal government to introduce cultural diversity into the workforce and our institutions of higher education. Thus, much of the diversity that exists in our workforce today would not exist without affirmative action. Affirmative action has positively influenced every facet of society–education, housing, health care, economics, and employment- inclusive of and beyond those benefits traditionally associated with African Americans (Atkins, 1988; Selingo, 1998; Stone, 1995; "Thousands March," 1997). In contrast, cultural diversity is not a government mandate and is inclusive of every member of the employee population (Middleton et al., 1996).

CULTURAL DIVERSITY is an inclusive, development-oriented notion that aims at retaining and empowering every segment of the employee population. Consistent with Pedersen (1991), we define culture broadly to include demographic variables (e.g., age, gender, geographical regions, disability status, affectional orientation), status variables (e.g., social, educational, economic), and ethnographic variables (e.g., nationality, ethnicity, language, and religion). Because *culture* is generic to all relationships, it includes every employee in an organization. Because of this inclusivity, views relative to cultural diversity must specifically address the referent culture(s), rather than being universally applied. One can have "cultural homogeneity" without having "diversity." Likewise, one can have "cultural diversity" without having "multiculturalism" (Middleton et al., 1996; Middleton et al., in press). However, cultural diversity is a requisite to achieving multiculturalism.

MULTICULTURALISM in the counseling setting is defined as the existence of a *prevailing* (dominant) environment originating from effective intra and intercultural exchanges. Individuals who respect, value, and learn from one another build on their *intercultural* exchanges, creating a *synergistic* environment that is both *dynamic* and *productive* (Middleton

et al., 1996; Middleton et al., in press). Multiculturalism is qualitative in nature and is the condition or state of existence within the clinical environment or culture of the organization (i.e., counselor or rehabilitation education programs). Is there synergy present in the environment? Synergy is a term derived from the doctrine of synergism. Synergism is the combined action of two or more agents that is greater than the sum of the action of one agent used alone. In this instance, every individual operates as a synergistic agent. Each individual in the environment brings a unique cultural identity to the environment. Thus, we establish the potential for synergism to occur. The combined effect of intra and intercultural exchanges between two or more individuals is greater than the sum of the action produced when individuals act or exchange solely within their own cultural framework..

CROSS-CULTURAL COUNSELING according to Sue et al. (1982), is defined as "any counseling relationship in which two or more of the participants differ with respect to cultural background, values, and lifestyle" (p.47). While Sue et al. did not define *culture*, we embrace the position endorsed by Pedersen (1991) that culture includes many human differences across demographic, status, and ethnographic variables. Much has been written about the culture-bound nature of counseling, psychotherapy, and rehabilitation counseling (Atkins, 1988; Atkinson, Morten & Sue, 1993; Casas, 1984; Leung & Sakata, 1988; Sue & Sue, 1990; Wright, 1988). Educators also have addressed cross-cultural issues in training and education (e.g., D'Andrea & Daniels, 1991; Leong, 1993; Locke, 1990; Middleton et al., in press; Ponterotto & Casas, 1987; Schaller & DeLaGarza; 1994). Very few writers have presented a discussion of possible cross-cultural issues in clinical supervision. What is urgently needed is an expansion of current supervisory models to incorporate intercultural dynamics. Brown & Landrum-Brown (1995) asserted that a logical starting place might be an integration of their supervisory process model with that of Loganbill, Hardy, & Delworth's, (1982) developmental model of supervision.

MULTICULTURAL COUNSELING COMPETENCY in treating culturally diverse populations is currently viewed as an essential component of therapeutic competence (American Psychological Association, 1980; Casas, 1984; Pedersen, 1991; Sue et al. 1982; Sue & Sue, 1990). Concern regarding multicultural counseling competencies was initiat-

ed with the publication of a position paper by Sue et al. (1982) who described multiculturally competent counselors as those who have moved from being culturally unaware to being aware and sensitive to their own cultural issues and to the ways that their own values and biases affect culturally diverse clients. Multiculturally competent counselors also: (1) consider factors such as the impact of the socio-political system on members of underrepresented racial/ethnic groups in the United States; (2) have knowledge and information about particular members of central underrepresented racial/ethnic groups; and (3) and are able to generate a wide range of appropriate verbal/nonverbal responses to client needs (Sue, Arredondo, & McDavis, 1992).

In considering the field of rehabilitation counseling, for example, Thomas and Weinrach (1998) cited several important contributors to the rehabilitation literature on multiculturalism (Leung & Sakata, 1988; Middleton, Flowers, & Zawaiza, 1996; Pape, Walker, and Quinn, 1983; and Wright, 1988). However, there continues to be a need to develop multicultural competencies and standards for the rehabilitation counseling professions in most counseling disciplines. Also lacking is the important roles that rehabilitation counselor training programs must play if multicultural competencies are to become a permanent part of the profession.

HISTORICAL BACKGROUND, ADVANCEMENTS IN HIGHER EDUCATION, AND IMPLICATIONS FOR THE NEW MILLENNIUM

INITIAL EFFORTS (1960S). Both philosophically and strategically, the modern movement toward reform in mental health services was a product of the 1960s civil rights movement. The civil rights movement placed a spotlight on concerns that had been neglected in counseling members of minority groups. Race, prejudice, and discrimination were discussed openly as significant factors in the counseling relationship (Jackson, 1995). The notion that minority group members were inferior to majority group members was questioned. The values of the profession of counseling mirrors the values of the larger society (Sue & Sue, 1990). By observing and using the strategies executed by African-Americans in the 1960s, many members of underrepresented groups (mental health patients, women, persons with disabilities, etc.) learned the value of overtly demanding their rights.

The Civil Rights Act of 1964 allowed for greater federal enforcement against discriminatory use of the increasing federal funds provided to institutions of higher education (Preer 1981). At the same time, the financial assistance provided by the Economic Opportunity Act of 1964 and the Higher Education Amendments of 1968 helped to turn access into a reality for many African American students and other ethnic groups.

EXPANDING EFFORTS (1970S). The term "minority" does not represent a homogeneous group. The number and variability of the people included in this category make the definition, at best, imprecise. Changing attitudes regarding who constituted a "minority group" were reflected in counseling and education literature, as agencies and individuals began to report on the various minority groups as separate populations (Astone & Wormack, 1990; Sue & Sue, 1990). According to Reynolds and Pope (1991), interest in multicultural and cross-cultural counseling issues grew substantially in the 1970s and generated a surge of innovative articles and research. Recognizing and understanding the differences within and among the various minority populations are essential elements in understanding diversity in counseling and human services for the new millennium.

UNPRECEDENTED GROWTH (1980S AND 1990S). The 1980s and 1990s witnessed unprecedented growth in the specialty of multicultural counseling. Professionals researched and wrote about diversity and multicultural counseling in record numbers. Debate ensued among many human service professions regarding the boundaries of multicultural counseling.

In the early 1980s, demographers began to warn of the impact that the decline in birthrates in the white population would have on college enrollments. At the same time, after the 1980 Census, demographers signaled the growing proportion of minorities in the general population and the shrinking proportion on college campuses. In response, college recruitment took on a new face. The renewed special emphasis on all of ethnic minority education from recruitment to retention, graduation, and entry to graduate and professional schools was fittingly being fueled by a national concern for economic well-being.

DECLINING CONCERN (MID 1990S TO PRESENT). What ever happened to integration? University of Virginia professor Julian Bond, asked this question just days before being elected president of the

NAACP in 1998. "Whatever happened to the '60s idea that the mere fact that Blacks and Whites could be friends, hold hands, and attend the same churches and schools, said something good about the society" (Ruffins, 1999, p. 18). Bond was expressing a sorrow felt by many older activists–a sorrow grounded in the belief that numerous people, including many African Americans, seem to have given up on the ideas that integration is a positive social good.

Middleton et al. (1996) point out that "the biggest shift in congressional power in 42 years took place on November 8, 1994, shifting the balance of power from a more broad-minded liberal Congress to a rashly conservative Congress" (p. 24). Additionally it was predicted that one could expect that the recent attacks on affirmative action would broaden and continue (Middleton et al., 1996; Middleton et al., 1998; Middleton et al., in press). We are not yet sure where society will finally position itself in preparation for the new millennium.
Nonetheless, diversity is essential for ensuring quality health care and finding answers to major health, including mental health, problems.

FUTURE TRENDS IN MINORITY ADMISSIONS IN HIGHER EDUCATION

College enrollment rates for minority students are disproportionately low, a fact this is particularly troubling. However, given the projected growth in the African, Hispanic, and Native American populations, university counselor and rehabilitation counseling training programs will increasingly find that the average college-aged students will not be of European descent. This inevitability is troubling, given the current underrepresentation of these populations at post-secondary institutions among faculty and students. A number of factors influence the degree to which African, Hispanic, and Native American students will attain advanced degrees. In essence, the quality of K–12 education available to historically disadvantaged populations, their tendency to enroll in two-year institutions at disproportionately high rates, and the enrollment patterns in college, all bear an influence. If not addressed, these conditions will continue to contribute to the disproportionately low numbers of these students who subsequently enroll in graduate and professional programs.

DIVERSITY IN COUNSELOR TRAINING PROGRAMS IN THE NEW MILLENNIUM

Society will not be able to address its serious social and economic problems if members of racial and ethnic underrepresented groups and other culturally diverse populations cannot access resources. Policymakers will be limited in their ability to make good decisions concerning the entire population if they exclude a growing percentage of the people impacted by their choices. Consequently, it is paramount that counseling and other human service professions find ways to consistently integrate these groups into higher education institutions as they struggle to equalize the conditions in primary and secondary educational cohorts.

At the postsecondary level, efforts to include historically disadvantaged groups should: (1) include the development of more reliable instruments to determine access; (2) provide initiatives to encourage the movement of these populations from two-to-four-year institutions; and, (3) develop programs to enhance these students academic success. Strategies might include faculty and peer mentoring programs, the provision of cultural programs, and establishment of tutoring programs. Lastly, efforts must be undertaken to transform the pedagogy and curricula of these institutions so that they reflect the changing nature of the student body.

Given the fact that arguments for affirmative action are likely to be supported by strong arguments for the benefits of supply-side diversity, the declining concern for diversity observed in the late 1990s will be replaced by renewed interest in the next millennium. We also may witness renewed support for strategies that mirror the outcomes of affirmative action. What are the implications for counselors and the counseling profession of the changing demographic trends in the U.S.? What is more likely to change is the ascendancy and multiplicity of service providers and training programs that adhere to the mandates of the culturally-skilled counselor outlined by Arredondo et al. (1996). Graduates who are not culturally-skilled will find it increasingly difficult to find employment. Service providers who do not employ a culturally-skilled, diverse workforce will find consumers of mental health services seeking out other providers in the competitive market place.

What future problems might human service professionals observe if current ethnographic trends continue? The stresses of being a mem-

ber of a marginalized and/or stigmatized group require coping skills for adequate problem solving. Without these skills and social support to use them, some may turn to abusing substances. Others may develop symptoms of depressive or anxiety disorders, and still, others will express their inner turmoil through violence or other antisocial behaviors. Should funding-related cutbacks in school and community mental health services continue, we likely will see in our society a concomitant rise in the incidence of behavioral and psychological problems that might have been relieved by prevention and early intervention programs.

One legacy of the 20th century in the United States is that the criminal justice system has become the institution of last resort for persons without financial means to address their psychological problems. Many of those incarcerated with mental health problems also are members of minority groups. Clinically, the challenge for mental health professionals and school and university counselors will be to continue to focus on understanding the interplay between cultural forces and intrapersonal forces shaping the world of the client. In the last 20 years, our knowledge of these forces has been greatly enhanced through the work of many clinicians and researchers (e.g., Helms & Cook, 1999; Ivey, Ivey, & Simek-Morgan, 1993; Pedersen, 1991; Ponterotto, Casas, Suzuki, & Alexander, 1993; Sue & Sue, 1990). Underutilization of counseling and premature termination of counseling by minority group members address the value of culturally relevant services that recognize the need to understand clients' mental health care beliefs and traditions, their explanatory models, and health-related social practices (Fabrega, 1990). In this regard counselors should be reminded that psychological distress will manifest itself in physical symptoms in some members of minority groups. Linkage with medical services may be an important avenue to reach these clients who would not otherwise seek counseling services.

DIVERSITY IN MENTAL HEALTH SETTINGS IN THE NEW MILLENNIUM

How do we proceed toward inclusion, knowing these data about diversity needs, educational access, opportunity, and outcomes?

Several authors (e.g., Bond & Pyle, 1998; Fong, 1995) have noted that for diversity efforts to be successful in the mental health workplace, they must (1) have a systemic focus and (2) be part of an intentional, long-term institutional focus on changing the institutional culture to promote diversity.

According to Gardenswartz and Rowe (1998), workplace diversity efforts are headed in the direction of systems change as well as in the direction of training in diversity management skills. Although it is important to focus on hiring practices that will produce a diverse mental health workforce, it is equally, if not more important, to build a diversity sensitive environment within the workplace. These efforts not only pay off in recruiting the best talent available, but also in retaining that talent, thereby increasing the diversity within the workforce (Lieber & Urresta, 1998). Employee turnover is costly to organizations, costly to clients being served by departing counselors, costly in management time spent in recruiting and retraining new employees, costly in employee morale, and costly in community perceptions. While we may hope to change attitudes in the mental health workforce, in the final analysis, behavior change on the job is the most measurable outcome of diversity efforts.

Change strategies that are successful and lasting cut through all levels of an agency, institution, or school. They reach the individual counselor, the work group and the entire organization (Bond & Pyle, 1998; Fong, 1995; Middleton et al., 1996). As we transition into the new millennium, commitment to diversity must be translated into significant shifts in jobs and resources, into smooth working relationships across differences, and, as mentioned previously, into the cultural transformation of organizations.

Organizations that have successfully incorporated a positive view toward diversity convey their commitment in their mission statements and through all communications that represent the organization. They consistently reflect diversity management in their recruitment of new counselors, their orientation to the job and work setting, performance appraisal, compensation and benefits, promotion, training, and development. It is important that all members of the staff feel responsible for contributing to the success of the agency or schools diversity efforts (Bond & Pyle, 1998; Middleton et al., 1996).

Several factors may account for the appearance of unstable or ambivalent commitment to diversity in the work setting. Despite the

seeming openness of those in the counseling field to respecting individual and group differences, that openness to difference may be less clear when applied to collegial or peer relationships. Although counselors may recognize and be accountable for their impact on their clients, they may overlook or fail to account for their impact on others in their work environment. Acknowledging interconnectedness and interdependence, contradicts dominant Western values regarding decisive, solo action. Responsiveness to the collective, and personal accountability for group effectiveness and the quality of the work environment are values that support diversity management efforts (Bond & Pyle, 1998).

The predominant view of inclusion of members of diverse groups in the workplace has focused on a "melting pot" approach (Alverson, 1998; Bond & Pyle, 1998), where members of the nondominant groups are expected to assimilate into a working group's norms, values, and behaviors. Bond and Pyle (1998) noted that most organizations and managers believe that respect for diversity is an important value in the work setting. However, minority group members may experience a difference between such formally stated values and the unwritten rules of the organization that are acted out on a day-to-day basis. For instance, Bond & Pyle (1998) have noted that managers who believe in diversity also believe that minority group members want to become and should become more like the dominant group. Organizations even invest in training to make minorities like the dominant group (e.g., assertiveness training). To extend the thoughts of Hooks (1984), managers and employees who are members of the dominant group give the appearance of being hosts who have invited minority group members into their organizations more as guests than as fully voiced, valued colleagues. One of the great contributions of a diverse work group is the availability of multiple perspectives, multiple interpretations that lead to creative outcomes. Silencing the voice of any member of a work group or promoting the expectation of a singular view is counterproductive when the goal of a mental health organization is to provide the best possible services to a broad range of clientele. The world outside the mental health or rehabilitation center or the school or the Employee Assistant Program is a world of many diverse voices, some of which have assimilated in to the dominant culture, but many of whom have not and do not wish to be.

In addition to the false adherence to a melting pot approach to diversity, fostering ambivalence or a lack of commitment to diversity in the mental health professions, denying that discrimination and harassment occur among mental health professionals may do so as well (Hemphill & Raines, 1998). Discrimination and harassment occur when counselors fear their reduced power in the work setting and fear the potential loss of job security when new colleagues with differing perspectives enter the workplace. These problems occur when counselors are confused as to how to behave in a diversified work setting. A focus on behavior and a written and enforced zero tolerance policy is one systemic change that demonstrates commitment.

Supervision of clinical work and oversight of other workplace conduct can provide significant impetus to counseling staff members who may evidence discriminatory or harassing conduct. Setting boundaries of acceptable practice in all areas of the work environment, not just discrimination and harassment, will make expectations clear to employees (Hemphill & Raines, 1998). Some (e.g., Gardenswartz & Rowe, 1998) have suggested that the workplace efforts toward diversity that focus on training of the workforce are well placed. For example, managerial and team skills are important for all employees. Staff at all levels need to learn skills in conflict resolution, cross-cultural communication, and productive problem solving in a pluralistic environment. Workplace policies and continuous evaluation need to include diversity skills in defining what constitutes excellent performance on the job. Minority group counselors as well as counselors from the dominant group should each be evaluated on the diversity criteria. Being a member of a minority group does not inoculate a counselor from being discriminatory or harassing.

What about other efforts to promote retention of staff who are minority group members? How does the agency or institution handle career advancement and mentoring? Supporting all employees in preparation for licensure and other forms of credentialing contributes to retention of employees. In addition, encouraging continuing education and involvement in professional associations at the local, state, and national levels can connect counselors with others to provide a network of support. Mentors who the employees experience as safe and confidential can be located in this way. This does not preclude the need for mentoring within the workplace. Networking at conferences

among other professionals, can draw minority counselors into the legacy of counselors and educators who have promoted diversity and brought the profession to its current status. Some may choose to become actively involved in continuing this legacy.

CONCLUDING COMMENTS

The literature concerning the recruitment of racial and ethnic minorities into counseling and other human service professions would benefit enormously from additional research and development in several important areas. The following ones are the most pressing. The first four relate directly to counseling and mental health services. The latter four relate directly to counselor education programs and institutions of higher education.

1. Identification and evaluation of model programs to improve the institutional climate and cultural pluralism on college campuses, university counseling centers, and other mental health work settings.
2. Development of multicultural competencies for all counselor and counseling related programs (i.e., social work, rehabilitation counseling, nursing, etc.)
3. Examination of cross-cultural issues in clinical supervision of counselors and other human service practitioners, and an expansion of current supervisory models to incorporate intercultural dynamics.
4. Investigation of factors affecting culturally diverse clients' access to and success with counseling services.
5. Analyses of cultural differences among minority groups and subgroups and their effects on minorities access and success.
6. Evaluation of college-wide recruitment and retention programs, especially those relating to specific culturally diverse groups.
7. Evaluation of innovative strategies for recruitment and retention that are culturally specific.
8. Evaluation of various state policies addressing transfer from two-year to four-year colleges, and an evaluation of college-based programs designed to increase the rate of minority students transferring to four-year colleges.

To be most effective in reversing the tide of exclusion, minority student enrollments in the mental health professions should emerge from

an institutional plan. The objectives of the agency's or institution's plan, however, should be considered as only part of the broader goal of educating and graduating more minority students. Institutions in higher education and mental health agencies should take a holistic approach to recruitment and retention, integrating recruitment with other professional objectives such as the counselor's professional performance, multicultural competency, social integration, cross-cultural counseling skills, cultural diversity, and multiculturalism. In developing and implementing the plan for recruitment, the perspectives of various constituencies should be considered, as everyone in the work/academic setting has an interest and an investment in the ultimate success of all clients/students.

An awareness of cultural differences is an essential part of designing a good plan for recruitment and retention, as well as of implementing it. While some strategies for recruitment can be used to recruit students from various ethnic and racial backgrounds, the manner in which the strategies are put into practice and the people involved would depend on the targeted population. As we transition into the new millennium, it must be remembered that an awareness of differing cultural values and needs is an essential first step to a truly culturally diverse setting and, ultimately, a truly culturally diverse society.

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Chapter 9

INTERNATIONAL VISTAS FOR COUNSELING

PAUL LEUNG AND WILLIAM G. EMENER

> Together you and I will begin to build the new society, a society in which each of us has the chance to grow, to achieve, to contribute, to create dignity for ourselves, and not for ourselves alone but for others also, a society in which each of us has a stake, a share; and we will give back to our children what they deserve–a heritage of hope. (Blair, 1997, quoted by Short, 1997)

This above quote by Britain's Tony Blair summarizes the vision and legacy that many of us wish to pass on, not only to the next generation but also those who currently live in poverty without the *resources* and the *choices* that resources provide. We were especially attracted to Blair's statement, as it is what we often hear that counselors want for the future.

This chapter along with the rest of this book is about what some of us see as the future for counseling. At the same time, we must remember that our future is grounded in our past and often the "baggage" associated with it. Too often, we have been parochial and provincial in our thinking. This has been particularly true for most of us in terms of extending counseling beyond our own immediate horizons. Our hope is that as counselors and helping professionals, our skills and expertise will positively impact more than our immediate communities, but rather a world much greater in scope and need.

We can look at the world in two ways. We can view the world in terms of the huge numbers of people in many different countries as totally unrelated to us. Looking at the world in this way, however, one can believe that there is little that an individual can do that will make a difference. Or we can view the world as a small one, following the perspective of the common saying that there are only six degrees of separation between any one of us. Those who we know face to face are the first degree. The second degree involves persons we don't know

but in whom we have mutual friends and so on until the sixth degree where we are all related. This view of the world suggests that whatever we do does have immediate influence. In addition, this view provides incentive and motivation, as we are not as anonymous as we think.

How we view the world has much to with what we do. If we see ourselves as isolated, we act in one way, but if we see ourselves as interrelated we act accordingly. For those of us living in well-developed and well-resourced nations, there has been a tendency to look within rather than without. With the many social issues of a contemporary society, we say we have our share of problems and we don't need to complicate things from outside our borders. We find ourselves justifying our inaction towards meeting the needs of the rest of the world because of internal needs. Examples abound especially among well-developed and well-resourced countries that would be illustrative of this national myopic view of the world. The Victorian Premier, the equivalent to a governor of an American state, recently offered Indonesia assistance in the way of economic expertise. Though the obvious bottom line was to cement ties with a trading partner, a wave of criticism came forward that there was enough to deal with at home and he had no business sharing resources with a foreign country. The arguments often voiced by Senator Jesse Helms in the United States related to foreign aid personify this perspective and is another example of isolationist rhetoric. As helping professionals, we do see needs and often feel we can do more on a local level than to turn to those in what we see as far away places. However, this may be an approach that is shortsighted and may be harmful to us in the longer term (Leung, 1998).

As we grappled with the issue of how to broaden the scope of counseling to fit the world context of the next millennium, we came across a paper by Kit Welchman (1996) in which he attempted to answer the question of what relevance is psychodynamic counseling to the social and political dilemmas and troubles of our time? Essentially, Welchman (1996) saw the personal as a paradigm for the political with application far beyond the typical one-to-one. We will come back to some of his ideas later.

GLOBALIZATION

Globalization, a term of economic origin, conveys a notion that has immense implication for all of us as we look toward the next millennium. Used strictly in its economic sense, proponents of this concept see globalization as a way to bring about more productivity and better living conditions for all. There has been much debate and controversy about whether this will occur. The events that have taken place in Asia in 1998, have seen fragile economies collapsing, resulting in huge numbers of persons losing their jobs while the prices for necessities are skyrocketing. Yet there is no debating that these events continue to have impact.

Used in a broader context, globalization suggests that people and nations are linked together in ways never before envisioned. For example, globalization is changing the context in which governments operate. The globalization of financial markets is just one aspect of this changing environment. Resulting challenges to policy makers are made more acute by a host of other "internationalizations" under way in areas such as population movements, crime, communications, and product and service markets. While communications are the logical extension providing us almost instantaneous access to one another, the recent Asian economic crises highlighted how closely aligned we all are. In countries where poverty has been indigenous and endemic, people are exposed to the more comfortable life styles of their cousins in well-resourced nations. Understandably, expectations rise as to what is required or needed not only in material ways but also in psychological comfort and freedom from stress. For example, the demise of some authoritarianism countries may be traced to increased exposure to self-governance. The gaps between those that have and those that have not, in a global world, must be eliminated or there will be growing disenchantment perhaps making us all at risk.

The white paper titled "Eliminating World Poverty" by the Department for International Development of the United Kingdom provided a vision of a global future that many of us share:

> We want to see a global society where everyone can live in peace and security; have a say in how their community is run; and have access to those things we so often take for granted, like clean water, fresh air and the chance to earn a living and bring up healthy, educated children. We want governments to be accountable to their people; obey the rule of law; protect human rights and create opportunities for economic growth. (Short, 1997, p. 2)

What is interesting is that the rationale provided for global development in this statement not only includes the customary moral duty but it also adds the proviso, "because it's in all our interests" (Short, 1997, p.3). In other words, the motivation is not only one of charity or goodwill. There is recognition that what happens in the rest of the world also affects what happens to the United Kingdom (UK) and other developed countries.

Most of the world, however, is quite different than the UK, the United States, or other economically well-developed countries. The reality of the world beyond developed nations is that a quarter of the earth's population survives on less than $1 a day. Seventy-percent of the population in these countries are women who have no access to education or health services, who feel isolated, powerless, and have little to say about how their lives are run (Short, 1997).

As counselors and human service workers, the ultimate issue is whether or not we have a role or a responsibility. Counseling is often seen as a human service provided to assist or help persons achieve their own goals or objectives. What place does it have in countries and cultures that are quite different from Europe, North America, and Australia?

COUNSELING'S HISTORY

Counseling, especially as a professional activity, has been essentially a white middle class phenomenon that has moved on to become a social institution in America and Europe (Sundberg, 1981). Counseling is an American product developed within the uniquely individualistic nature of American society in conjunction with the affluence that made it affordable (Shertzer & Stone, 1974). Albee (1977) observed that psychotherapy came about in response to the decline of the Protestant Ethic and the subsequent glorification of the self in a consumption-oriented capitalistic society. Thought about in this way, counseling loses some of its altruistic luster. In addition, only relatively recently has there been an extension and recognition that counseling may have broader application to other racial/ethnic minority groups. Even the development of the multicultural model has not been without debate. Counseling came about within a very narrow base but

has grown because counseling is relevant for large numbers of persons in a society able to afford to pay for it.

The society of the next millennium may be quite different. There are glimpses now of what the future may bring. The human concerns that brought about the need for counseling continues to occur regardless of national borders. Conflict, occupational choice, and personal growth are part of what it means to be human no matter where one resides. While counseling may be a cultural solution to personal problem solving and while there may be serious questions about the ethnocentric application of psychotherapy to other societies (Sundberg, 1981), we believe there are applications for counseling if adaptations can be made and counseling is seen as more than a means of livelihood for those who practice it.

First Steps

To be transferable and to be effective beyond western countries, the counseling process must take into account a different reality. Sundberg (1981) related the differences in career choice and decision making by Indian youth of south Asia to what occurs in the United States. He suggested that there are far fewer choices in an economy where young people must take whatever work is available and where there are very few opportunities. Soliman (1991) included limited options as one factor that influences the implementation and practice of counseling. In addition, Sundberg (1981) cited the strong family influence, lack of mobility, financial constraints, and differences in understanding of privacy and openness of many cultures as evidence that counseling models used in the West may have little utility in other cultures. The very concept of counseling may be foreign to developing countries (Soliman, 1991).

Sundberg (1981) suggested that "every culture probably has some method for handling individual problems that are not easily solved by the social structure" (p.322). Guidance in many other cultures has often involved elders and older generations passing on information valuable for survival. Now working and living in Australia, this chapter's first author, Dr. Leung, is fascinated with the Aboriginal Australians who may be the oldest continuous cultural ethnic group surviving today. The Aboriginal ways are passed on through elders;

often, their stories illustrate their connection to the land. Aboriginal stories are not abstract ancient ideas but rather have immediate current reality. Listening skills, so central to the western counseling process, may assist young persons in these cultures, who are torn between their tradition and westernized schooling, to better understand in their own context the meaning of these stories. The bridging of different generations, especially those in which there are immense cultural gaps, cannot occur from a one-sided approach in which one culture is ethnocentrically seen as superior to another. The counseling essential of unconditional positive regard indeed has implications of acceptance beyond the individual. For example, this chapter's second author, Dr. Emener, in his private practice as a licensed psychologist, frequently sees clients who recently came to the United States from other cultures around the world. Inviting his clients to assist him in understanding the cultural mores, folkways, and overall genre pertinent to their lives and issues is central to his understanding and helping them. The challenge for the next millennium is for counseling to adopt to a different paradigm, one that will be applicable in a much different context. While counselors in developed countries may continue their present roles and functions, the relevancy of counseling practice for the next millennium ultimately will be determined by how it adapts to the rest of the world.

We suggest that professional counselors can use the basics of the helping relationship and find new ways to practice them. Perhaps because western developed countries have the power and the resources, especially the United States, they have long been seen as having the "answers" and "solutions." Solutions that have been successful in the U. S. often have been adopted and used sometimes without real thought about their implications. Ironically, there is a tendency to believe that what has worked in the U.S. will work elsewhere and that when they do not it is a function of the lack of resources.

Hamby (1998), in discussing domestic violence intervention, points out that too often programs developed and applied from a white, middle-class perspective are extended to other groups with the effect of imposing white, middle-class values along with the services offered. Interventions are only modified in a cosmetic way and therefore fall far short of making meaningful adaptations of program content. Other adaptations may be nothing more than "gratuitous

changes" that may typically include endorsement of a consultant or focus group who belongs to the target ethnic or cultural group solicited (Hamby, 1998). Furthermore, Hamby (1998) suggests that only genuine changes would be ethical and acceptable. For example, Pearlstein (1998) points out that the success of Xerox as a viable business was due to its ability to change, learn, adapt, and shed old models that no longer apply. Likewise, any helping paradigm to survive successfully must not remain static without regard for the context. If counselors really believe that they have something to offer, they must be able to shed older counseling models that are no longer relevant, and in terms of a changing context, adapt to meet and accommodate different conditions.

Bojuwoye (1992) lamented the slow evolution of counseling activity in several African nations and suggested the difficulties to be related to funding and attitudes. First, Bojuwoye pointed out that literacy eradication is more of a central concern than the "luxury of personal counseling" (p. 6). Likewise, Bojuwoye (1992) thought that too much emphasis had been placed on behavior changes as desired outcomes.

It is important to remember that developed countries are a minority within the world scene. Developing countries contain most of the people and still hold most of the natural resources. The agenda of these countries will become increasingly important. Even now, this is reflected in the debates occurring within the United Nations. At the same time, it can probably be safely said that it is also in developing countries that the majority of the conflicts occur and that survival is more of an issue than career choice.

DIFFICULT CONCERNS

One of the major concerns in many developing countries relates to their citizenry and their relationship to government. The evolution toward democracy is not always easy and there have been individuals and groups intent on governing by might alone, essentially operationalizing the philosophy of jingoism. The resulting psychological and emotional effects of political repression, however, is perhaps difficult to imagine, but for many people throughout the world, it is very real (Comas-Diaz et al., 1998; Garcia & Rodriguez, 1989). Garcia and

Rodriguez (1989) indicated that political repression has been used by governments to maintain power involving persecution, torture, and murder, as well as the captivating and abandoning of children with all of the accompanying stress and abuse. Comas-Diaz et al. (1998) point out not only the personal damage but also the harm that occurs to the social structures such as the norms, values, and principals "by which people are educated and the institutions that govern the lives of citizens" (p. 779).

Comas-Diaz et al. (1998) believe that psychology must begin to construct theory that will enable an empirically developed psychology to "inform the survival, healing, and reconstruction" of societies affected (p. 779). Garcia and Rodriguez (1989) further suggest that therapy can assist in bringing about solidarity, increased respect for self, and the enhancement of ego functions. In addition, group work can be helpful for the dilution of anxieties and the amelioration of guilt. These are tasks that professional counselors easily can accomplish in assisting people; furthermore, these are tasks that are not uncommon in many developing countries. From an international perspective, however, there will have to be conscious efforts to adopt a different and broader helping model.

Another area of probable need for professional counseling services, is the increasing transitory nature of people. While moving within a country is not unusual in the United States or other developed nations, migration that comes about because of social and political upheaval probably places greater stress and anxiety on people. Cook and Timberlake (1989), in describing counseling with refugee populations, postulated that counseling assists the process of not only making sense of the contradictory values and beliefs of two different cultures but coming to grips with multiple losses. There are still huge numbers of people experiencing dislocation because of conflict and power struggles. Again, the need is to intervene in a different way than one-to-one counseling.

Counselors must look beyond the shores of western developed countries and perhaps be a bit more imaginative about what counseling is all about. Moreover, is it important that they speculate about its utility for non-western developing nations. The very nature of the counseling process suggests applications far beyond. Is it possible to translate helping principles that will allow application to large groups?

Can counseling, through existing institutions, facilitate ways to alleviate stress and provide alternate ways of coping?

WHY COUNSELING (OR WHAT CAN COUNSELING REALLY OFFER)?

Counseling is often defined in terms of changing behavior or a "redirection of typical responses to frustrations or different attitudes toward other people or to self" (Shertzer & Stone, 1974, p. 22). Certainly, help in problem solving and facilitating wise choices are often identified as the objective (Shertzer & Stone, 1974). Still others see counseling as prevention in the sense of preventing problems from getting worse.

Counselors in developed western cultures have served multiple purposes. Career choice, stress reduction, coping with disability, poor health, conflict and domestic violence, assistance with learning and education, interpersonal relationships, etc. all have been considered counseling-related functions. Counselors work out of schools, public and private agencies, and in a myriad of unique settings (as discussed in Chapter 6). Counseling has sometimes been mandated by legislation or as a result of judicial intervention. These interventions are often seen as commonplace and even taken for granted. However, for countries with a different social structure and order, counseling is novel and without precedent. The very nature of what counseling is all about must be dissected and restructured to fit the problems and circumstances of the setting.

Soliman (1991) suggested a need for a working definition of counseling that is comprehensive but also *distinctive* so that it will serve the diversity of needs in different settings and countries. Soliman (1991) basically accepted the American Psychological Association's Division 17 (Counseling Psychology) definition as operational but pointed out the need for operational definitions of concepts such as "effective functioning." For example, from an international perspective the expressions of "right" and "wrong" would have no place in a professional counselor's repertoire; rather, considerations of "functional" and "dysfunctional" would more likely embrace important facilitative utility with clients.

The previously cited white paper by Short (1997) pointed out that there is a need for "genuine partnerships." The role of developed and wealthier nations is one of support and of greater choice in their use of resources. Sometimes those who provide the resources dictate or impose conditions that may not work, or the manner by which the resources are provided are perceived as offensive and therefore rejected or not utilized.

STRATEGIES

One of the characteristics of developed industrialized countries, especially those that have free market-based economies, is the ownership of property, including ideas. Good ideas are translated into money through their sale by those who need it. Counselors and other helping professionals sell their services. Much of the energy within professional counseling organizations has been spent in licensing issues and to ensure access to managed care (both of which are "western-world" and "economically-solvent-world" considerations).

We believe that less developed countries and their people need what counseling has to offer, but quite frequently, the existing social systems in their environments prevent their being provided and used. For example, the psychological needs of people in less-developed countries are no less than others, but the smaller resource bases in their environments may not allow the luxury of professionals being paid to assist them in meeting their needs. Thus, there is need to more effectively combine traditional helping mechanisms with counseling processes in such a way that will not burden them economically. Mays, Bullock, Rosenzweig, and Wessells (1998) point out the "daunting task" of blending traditional psychology with multidisciplinary models. "Few roadmaps exist in the traditional training of psychologists for conducting psychologically informed interventions at multiple social levels or on the large scale needed for coordinating psychological work with the broader tasks of political, economic, and social reconstruction" (Mays et al., 1998, p. 738).

This broadening emphasis will involve counseling as an application of psychology and will require a shifting of focus from the individual to something more comprehensive and all encompassing.

Comas-Diaz et al. (1998) believe it is more than merely a cumulative effect of multiple trauma but and extension to the culture and the collective being of the society in question. Comas-Diaz et al. cite examples where psychology responds to people rather than treating people by using narratives within community workshops that explore the ethnic and cultural impact of violence. Counseling with its psychological base is no different. The perspective of the individual is of lesser importance and must extend to think more in terms of the wider impact of violence on history, culture, and community. Basically, there is a need to understand the logic and worldview of the particular culture (Comas-Diaz et al. 1998). Shore's (1998) case for advocacy suggests that psychology has to be more active within communities with the framing of mental health to include a broad ecological context.

Bojuwoye (1992) argued for the need to better incorporate counseling within the educational system and, specifically, the secondary school where counseling is more than the "exclusive presence" of school counselors. Bojuwoye (1992) espoused that placing counseling within the mainstream of curriculum will allow for improved teaching and communication strategies. Perhaps the notion of the teacher-counselor would embed the counseling role as fundamental to the educational process. The ideals of unconditional positive regard, empathy, and congruence would allow students to learn in an environment where they could examine the choices available. In some ways, this paradigm is not unlike that found even in the United States where teachers have traditionally been available to counsel and provide support to students. It does mean perhaps more formal preparation and work on the part of the counselor-teacher.

COMMUNITY BASIS

There has to be appreciation for the fact that helping must come from communities and evolve to the extent that it attends to the local situation if it is to be effective and relevant. Sundberg (1981) suggested that more attention be given to "folk counseling" or the use of "natural systems." Cook and Timberlake (1989) pointed out the need for helpers to become intimately involved with respective communities and families with the view that professional helping as known in the

West can be seen as part of the traditional helping relationship. In rehabilitation, for example, the worldwide model, as adopted by the World Health Organization, has been community-based rehabilitation in part due to recognition that unless communities own and adopt rehabilitation, rehabilitation will not be effective. Sundberg (1981) saw the adoption of "counseling in the large," or more indirect approaches akin to community psychology and community mental health, as potentially viable. Mutual support always has been important, and oftentimes secondary migration following initial immigration to a country occurs as individuals and families search for support (Cook & Timberlake, 1989). Creating and capitalizing on existing mechanisms and structures that provide psychological support will go a long way. In conjunction with support, an "early warning system" may be necessary, one that can detect when things are beginning to move beyond the capacity to cope. For example, using health workers including medical practitioners already present in the community may be the only option available.

Mays et al. (1998) emphasize the need to strengthen communities' abilities to do psychological work. Some common principles that can guide solutions are:

1. Solutions work best if they are locally controlled and administered, and if they acknowledge cultural, ethnic and gender diversity.
2. Solutions must build on local strengths and resources (a) if they will be sustained and (b) if local weakness are repaired.
3. Solutions must address themselves to ameliorating economic and structural inequalities and promote human rights (Mays et al., 1998).

A first step is to develop programs that train communities or key persons in communities. Furthermore, it is important that the solutions are not perceived as *imposed solutions from the outside* but rather as *solutions developed in the inside by people in the inside.*

BROKERS BRIDGING GAPS

The changing world has brought about differences in what young people face as compared to what their elders faced when they were young. In essence, societies may be "undergoing rapid social changes partly brought about by urbanization, increased travel, greater access

to dangerous substances, [and] the spread of telecommunications across cultural boundaries... [thus] making it increasingly more difficult for adults to base guidance upon their own experience when young" (Friedman & Hedlund, 1991, p. 60).

Friedman and Hedlund (1991) described a World Health Organization (WHO) developed counseling skill training package which incorporated cultural specificity with a nondirective counseling strategy built on effective listening with behavioral techniques used to train specific interpersonal communication skills. The primary focus of the package was cultural adaptiveness, which is but one aspect of the longer-term viability and use of counseling. Additional concerns include who will be trained in its use, and to what extent the use of the package and resulting outcomes will be sustained. We herein are suggesting that it is not only the adaptation of counseling in culturally appropriate ways but also the affordability of the delivery that is important. Training must not be a "one shot" exercise but rather a longitudinal, culturally engendering experience.

Conflict resolution is an area that has potential in the future of counseling in other parts of the world. Some have described conflict resolution as problem-solving using communication (Sweeney & Carruthers, 1996). Fittingly, conflict resolution may be a counseling-based, logical activity. For example, the cognitive model of Albert Ellis's rational emotive behavior therapy has been used to explain the constructive outcomes of conflict resolution (Sweeney & Carruthers, 1996). Likewise, Aaron Beck's cognitive psychotherapy model addressing how decisions and conclusions are drawn, equally can be applicable and effectively used. Two basic assumptions related to conflict resolution philosophy are that (1) conflict is natural, pervasive, and inevitable, and (2) conflict resolution processes take different forms and lead to different outcomes (Sweeney & Carruthers, 1996). One of the fundamental aspects of conflict resolution is that both parties in conflict share some of the responsibility for its resolution. Perhaps what is important in terms of application of conflict resolution in developing countries is not only the incorporation within the schools but also the use of peers whereby, for example, students can be their own agents of discipline and resolution of the conflict (Sweeney & Carruthers, 1996). As an aside, remember our previous address of the importance of "training as a longitudinal, culturally

engendering experience"–these students are their countries' future leaders!

SPECIFIC TARGETS

One of the more interesting applications of counseling within developing countries relates to efforts to deal with the HIV/AIDS epidemics. These examples provide some clues for the extension of the traditional counseling model that appears to be effective. Lie and Biswalo (1994), for example, asked Tanzanians what characteristics would they deem important for a HIV/AIDS counselor. The person preferred essentially resembled the client-centered counselor described by Carl Rogers. In addition, Lie and Biswalo (1994) found the critical issue to be: "Who should be informed and how, to minimize the risk of rejection, and to maximize the mobilization of social support and existing coping resources" (p. 148). Particularly significant is the finding that interviewees were more concerned with relationship oriented problems than with the facts related to HIV/AIDS (Lie & Biswalo, 1994), which again underscores the critical relevance of counseling's client-centered philosophy.

Campbell et al. (1997) discussed the role of HIV counseling in the context of developing countries with the conclusion that couple and group counseling may have a specific role. They emphasized that the individual counseling approach is often neither feasible nor practical. Campbell et al. (1997) further suggested that group sessions can provide for peer support, sharing, skills building, and behavioral modeling. At the same time, they emphasized the need to understand community and cultural issues such as "wife inheritance," where the husband has died of AIDS and the extended family wishes to know if the inherited wife is HIV positive.

SHARING RESOURCES

Resources always have been, and probably always will be, a crucial issue. As indicated earlier, the counseling enterprise in developed countries resulted at least in part from the ability to afford it. And as

has been apparent, many nations especially those still developing economically will not be able to afford counseling as it is often currently practiced. In the next millennium, there will be an amplified need to share resources that will allow for counseling to be implemented and available.

Resources should not be used for duplicating what exists but rather for developing ways to use counseling knowledge and expertise in addressing specific issues and problems. Understandably, there will have to be alternative funding mechanisms that allow for attention to concerns about quality of life. There also must be an awareness by people that support and help are available.

For those of us living in developed nations, such as the United States, we must be willing to give up some of what we have and to "give it away." The previously referenced UK white paper proposed forums that will increase public understanding of "why we depend on each other" (Short, 1997). The "give it away" challenge to counseling (similar to that offered to psychology [Comas-Diaz et al., 1998]) can best be addressed by *working in collaboration with* (not for) individuals and groups in their own countries in helping them create and determine their own identities and their own destinies.

PRACTICING COUNSELING

Soliman (1991) presented several guidelines for the provision of counseling services in developing countries. They include: (1) assure the freedom of the client, (2) assist clients to be aware of their needs, (3) use a scientist-practitioner model, (4) study the local culture, and (5) do not limit counseling services to a one-to-one model.

Helping Societies Cope

Mention was made earlier in this chapter about how counseling can assist people in the process of dealing with debilitating effects imposed on a population by governments. Entire societies can encounter parallel human experiences; as suggested, basic counseling principles indeed can assist entire societies cope. Welchman (1996), for example, suggested that whole societies may have repressed historical

hurts and victimization. Nonetheless, denial and blocked mourning that can prevent societies from moving forward in constructive ways can be processed therapeutically and effectively. Welchman (1996) cited the difficulty that many Japanese people have had in acknowledging the atrocities of the Second World War and that many Europeans have in acknowledging the oppression of colonialism. Interestingly, a similar situation currently exists in Australia related to the treatment of the Aboriginal peoples.

CONCLUDING COMMENTS

There is a bright future for expanded internationalization of professional counseling in the next millennium. Perhaps, however, none of us are able to predict exactly what that future holds. It undoubtedly will be quite different than anything most of us can envision. All that holds true for individuals, also holds true for countries. Importantly, individual cultural and social situations must be taken into account.

Principles and processes of counseling in total may be less important than the bits and pieces. Dealing with depression, anxiety, guilt, lifestyle and family pressures, occupational and economic stress, among numerous other human conditions, all represent targeted conditions for which professional counseling can be extremely helpful. Furthermore, high-level listening skills, empathic understanding, and genuine respect and positive regard are sin qua non to effective helping. Thus, targeted conditions and situations may provide much opportunity for professional counseling to be practiced pretty much as it is in developed countries.

For the developing world, counseling cannot be promulgated exclusively on narrow, specified systems; it must interface wisely with local systems that are in place. Support mechanisms, furthermore, can be enhanced through using basic helping principles. Professional counseling roles may have to be divided among several individuals or programs. Consultation and training will undoubtedly be more of the role(s) that counseling professionals play in the future. Fee for service that is typical of the private practitioner would not seem to be a viable alternative for much of the developing world. In fact, should a fee-for-service be a necessary quid pro quo for service delivery, it would be a

tragedy. In most cases, the needs are too great and the costs would be too high.

If you are a prospective or current professional counselor, a person who enjoys testing challenges and equally enjoys intrinsic growth, development, and the numerous other benefits of helping people, the international vistas for professional counseling are boundless and beckoning.

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Chapter 10

THE HUMAN SIDE OF HEALTH CARE IN THE NEW MILLENNIUM

MALISA W. JANES AND WILLIAM G. EMENER

If you have digested the contents of the first nine chapters of this book and questioned its relevance to your life as a professional counselor, then you are ready to join us in Chapter 10. The purpose of this chapter is to speculate as to what life may be like for a professional counselor in the new millennium–from the personal side. (We purposely did not tell any of our esteemed colleagues that we would be trying to empathize with professional counselors two or more decades into the future; we were afraid that they would insist that we be placed on medication.)

First, we discuss what life may be like for all people in the new millennium. Second, we discuss some of the critical phenomena of health care in the new millennium that will directly and indirectly impact the life of the professional counselor. And third, we offer a brief, tongue-in-cheek look at "A Day in the Life of..." a professional counselor, any Friday, 2010.

By design, this chapter contains more crystal-balling than any of the other chapters. All we ask for is serious consideration and respect; the next decade or two will determine the accuracy of our forecasting (and by then we will be retired and not care if anyone laughs at us).

LIFE IN THE NEW MILLENNIUM

We suggest that there are six distinct phenomena that will impact heavily on the lives of all people in the new millennium. The six factors, which also are directly and indirectly pertinent to professional

counseling, are: (1) stimulus overload; (2) excessively high expectations; (3) fast pace living; (4) multi-tracker life styles; (5) a redefined aging population; and possibly the most potent of all, (6) electronic cyberspace living.

Stimulus Overload

In the mid-1980s, it was not uncommon to walk into the family room of a home on a Saturday morning and find David: a teenager, lying on the floor with a headset on listening to music, a joystick in his hand playing a video game, watching a cartoon-character movie on another television screen, and waiting for a friend to call on the cordless phone. David's aghast parents feared that the stimulus overload their child was experiencing would cause some kind of brain damage. By the mid-1990s, however, David's 1980s behavior was perceived as normal for someone in the slow lane, and David's previously aghast parents were mimicking his multitask behaviors of the 1980s: briskly walking on a treadmill, listening to a talking book tape through earphones, watching the stock market report on a television screen, and talking with a friend on their cellular phone.

Though many people are developing adaptive behaviors to take advantage of technology, the ultimate question, however, may be: How much stimulus is the human being capable of before serious mental and physical illness sets in?

There already is a growing trend for more and more people to want a vacation where "peace and quiet" is guaranteed. Should the current "stimulus overload" lifestyle trend continue, by the first quarter of the new millennium, we may find advertisements for "something every home needs"–a personalized stimulus deprivation chamber and an on-call counselor with credentialed specialization in stimulus overload. A counselor in the new millennium might expect to find many overstimulated people who react similarly to those who suffer from agoraphobia, as well as an increased number of youth with nervous disorders, prescription drug addictions, and self-abuse.

Excessively High Expectations

There would appear to be an upward spiraling trend for people to expect too much of each other and correspondingly too much of them-

selves. Today, "pushing the envelope to the max" is a term heard throughout business and industry. "The thing to do" in the 1990s is to be sure that our collective and individual goals for a future target date are above and beyond our accomplishments for the previous period of time. If a department or unit produced X over the past three months, why does everyone feel that to be successful and to be able to feel good about themselves they have to produce 1.05 percent X over the next three months? "Doing more with less" also has been a watchword of the 1990s, and if this trend persists, we will continue to do more with less until the real price, the human price, becomes the ultimate cost involved. Thus, it would not be surprising to find many people in the new millennium working harder and harder yet feeling less and less successful. Of course, the anxiety and depression associated with this Zeitgeist indeed may produce a burgeoning client population for professional counselors who will have specific treatment skills in this area.

Fast Pace Living

The above discussed excessive high expectations, in turn, will produce a fast pace lifestyle that people will feel expected to live. In the 1980s if a person hurried and rushed all day, he or she could be expected to be at the head of the pack. By the late 1990s, however, hurrying and rushing is necessary to stay with the pack. Should this fast paced craziness continue into the new millennium, and indications are that it will, instead of slowing down (and accordingly adjusting ones expectations as to what is a realistic measure of success for maintaining high level self-esteem (Lyddon, 1990), people may resort to chemistry and self-medication in order to live the "necessary" fast paced lifestyle. Highly marketed vitamins, medications, and food supplements may allow us to "keep up" until we go too far. It is unknown whether society and/or the human race will self-destruct when stressed to the limits *OR* whether biological determinism will take over and humans will mutate to meet survival needs. With continued advancements in medical science, humans may have the potential of replacing the weaker genetic links in vitro, thus allowing those persons who can afford the costs to create "super stress resistant multitasking progeny." If society moves toward a social influence approach to value setting

(Johnson, in Kanfer, 1980), the reality is that these humans will become the super race and all others will be perceived as less valued in society. Again, another potential client population in need of professional counseling in the new millennium.

Multi-Tracker Lifestyles

In his book, *Adult Loving Relationships*, Emener (1998) discusses being a "uni-tracker" or a "multi-tracker." A uni-tracker is a person who can do anything quintessentially well; however, he or she can only do one thing at a time. A multi-tracker is a person who can do many things well, simultaneously. Neither one is necessarily better than the other. As we move into the new millennium, nonetheless, probability would suggest that the multi-trackers will have a much better chance of surviving and "succeeding," especially in corporate America, and the uni-trackers will be considered lazy and relegated to being in the lower, worker-bee echelon of society. Should this truly become a reality, however, the uni-tracker worker-bees may be happier and live longer than the multi-trackers. Moreover, we believe that happiness and longevity will become increasingly important in the new millennium. If we know one thing from history, it is that it repeats itself, and this trend already is beginning to surface. Witness, for example, the number of people who are dropping out of the rat race, moving back to less populated areas, and setting up home businesses so they don't have to deal with the stressors of the corporate environment. Additionally, this trend reveals an increasing number of parents who have traded traditional breadwinner roles and who are homeschooling their children and sharing in child-rearing responsibilities. Concomitantly, a division of people into the multi-taskers versus the uni-taskers will create debilitating dissonance in partner and marital expectations; this, in turn, will further expand the need for family, relationship, and marriage counseling in the new millennium.

A Redefined Aging Population

A change in life philosophy will accompany the increased age of the world population. With medical advances and prolonged lives, people are going to have to readjust their thinking with regard to older

people in society (Baltes & Baltes, 1998). In the 1990's we have seen advanced medical science and technology extend lives 20 years on the average compared to those in the 1950s. As a result, numerous compelling and obliging social issues come to the fore–issues that must be addressed in the first part of the new millennium. For example, we predict that society will begin to "re-frame" older age groups based on their continued usefulness and productivity. For many older individuals there will be a complete shift in their financial as well as in their ego support needs. In their "second adolescence," in which responsibility is lessened and fiscal worry is diminished, yet physical ability is retained, older people will be reaching out to try things that are missing from their younger days. Counselors will be needed to help seniors find the road to their "avocational dream" and decide "what to do when they grow up."

Electronic Cyberspace Living

At the turn of the last century, the telephone most certainly changed the lifestyles of people. Next came radio, then television. Now it is the computer and the Internet. In the mid-1980s, computers were primarily the province of science, engineering, and business. By 1998, however, approximately 40 percent of all households have computers and roughly one-third of those households have access to the Internet. And while the current use level suggests that the computer and Internet access is a luxury, early into the new millennium, these commodities will become necessities.

Recent research by Kraut et al. (1998), however, has found some potentially alarming effects of Internet use on the human being:

> This research examined the social and psychological impact of the Internet on 169 people in 73 households during their first 1 to 2 years on-line... In this sample, the Internet was used extensively for communication. Nonetheless, greater use of the Internet was associated with declines in participant's communication with family members in the household, declines in the size of their social circle, and increases in depression and loneliness. (p. 1017)

Scary isn't it! Again, with this trend obviously upon us, another client population for professional counselors emerges. We wonder how long will it take before "IDS" (the Internet Depression Syndrome) will become a DSM category.

Tongue-in-cheek aside for a moment, it will be important for professional counselors to remain keenly aware of the new millennium lifestyle and its effects on people, especially on themselves. With increases in new millennium lifestyle stressors and spiraling complexities in providing mental health services, it is proposed that professional counselors themselves will have an increased need for counseling. In the new millennium, out of necessity, the best among us may become "Counselors' Counselors" (and affectionately thought of as "the lifeguards of managed care").

LIFE IN HEALTH CARE IN THE NEW MILLENNIUM

As the storm roars and the waves beat upon the shore, the dunes are changed for ever. So, too, the storm of social change is transforming counseling as we know it. In the new millennium, the definition, intent, and scope of professional counseling will change, possibly beyond recognition.

Change in the new millennium will be occurring at an geometric rate. Slow, arduous, well-thought-out, and slowly evolving change will be replaced with rapid, revolutionary-paced, and dictated change. The ides of change also may change. Historically, the best predictor of the future was the past; in the new millennium, the best predictor of tomorrow may be today.

The new millennium will place the professional counselor in an ever-changing role, a role not necessarily changeable in substance (e.g., the critical content knowledge, skills, and attitudes have been fairly well established) but in focus (Cranswick, 1997).

Importantly, professional counselors in the new millennium will be high achievers, idealists with unrealistic expectations and almost unattainable goals. They will have little freedom as they will not be able to control the variables which affect their own behaviors. Many will be prime candidates for serious anxiety, depression, and burnout. Attending to people who struggle in high seas and whose ship just sunk is extremely challenging; however, it is much more difficult if the counselor is with them in the life raft. Having confidence in what one is doing is sin qua non to efficiency and effectiveness. Knowing what you do well (awareness), what is best referred to others (intelligence),

and how to create a therapeutic situation (action) that yields success will be critical (Dalton, 1961). However, when things are changing rapidly on all fronts it can be difficult to realize and appreciate accomplishments which are necessary to maintain ones confidence.

"Who is my client?" is a critical question for professional counselors. The new millennium, nonetheless, will witness new and ever changing client populations coming to counselors for help. Preparing oneself for them will be very challenging. Counselors will need to have a clear-cut appreciation for the differences between certain groups and for which groups they are professionally prepared and best suited to serve. Professional counselors also may need to be more consultant than counselor in serving certain groups as their needs and the real rationale for serving them may be vague. For example, would a counselor be asked by a company to assist anxious employees because the employees are suffering from anxiety disorders, or would a company want the counselor to reduce their employees' anxiety so that they will be more accepting of unrealistic expectations and produce more in less than desirable working conditions? Thus, the line between what is ethical and what is unethical easily could become blurred in the new millennium if professional counselors do not work together and cooperatively address the entrepreneurial Zeitgeist of the new millennium.

Anticipated outcome measures of counseling will need more specificity in the new millennium if managed care is to continue to solicit our services. Professional counselors also will need more specific agreements regarding what benefits are expected, for whom, and under what conditions.

The current managed care trend of the 1990s would suggest that in the new millennium the power brokers, who direct and control many of the phenomena necessary for professional counselors to do their work, may not negotiate with or work with counselors when making decisions. Professional counselors will be ill-advised to assume that those who hold the controls will understand, appreciate, be respectful of, and value the work of the professional counselor. In the past, too few counselors formed groups that maximized their breadth of specialities, and they did not maintain adequate outcome data to justify their employment to healthcare administrators. Professional autonomy may be further eroded in the new millennium if professional coun-

selors are not more aggressive in marketing their services and providing outcome data. Additionally, there will be an enhanced need to actively seek board seats to assure access into the board rooms where the ultimate decisions are being made. Three critical decisions on behalf of professional counselors, or any true professional for that matter, are:

- *Who do I serve?* For example, a professional counselor must retain the right to be able to work, or not work, with any given individual (for legitimate reasons).
- *How do I serve?* How a professional counselor works with a client is his or her call and may include making a referral to another counselor who has a specific speciality that is needed (e.g., the attending professional is the one who develops each client's treatment plan).
- *When do I terminate services?* When services should be terminated, is contingent upon the prerogative, the professional judgement, of the attending professional.

Given the current trend in managed care, how will these decisions be made in view of pressures to make decisions based on cost-effectiveness (Buchanan & Alston, 1997), "right to life" issues, and possible national healthcare contingencies? Professional counselors in the new millennium may have to speak out in favor of ethical actions in conflict with politically supported trends.

Continuing advancements in medical technology indeed will impact the work of the professional counselor. For example, in the 1940s and 1950s rehabilitation medicine produced new client populations (viz., individuals who previously would have died) with new found functional capacities. In the new millennium, potentials for genetic splicing and repairs in-vitro hopefully will render fewer individuals with disabilities yet at the same time generate needs for counseling associated with numerous other issues associated with such procedures. Furthermore, who will be responsible for underwriting and providing such services (e.g., the public sector or the private sector)? Similar social-ethical questions will arise with prolonging the life of older citizens.

With the new millennium will come ever changing governmental configurations and structures. An obvious spin off concern will be, "Where and within the auspices of which branch of government will counseling services be provided?" How governmental constellations will interface with private enterprise, also may be confusing and ever-

changing. It is conceivable, for example, that in the new millennium "counseling services for abused women" may (1) at one time be provided within governmentally funded and operated programs or agencies, then (2) within a period of time be funded governmentally yet offered through private, not-for-profit programs, and then (3) under the auspices of, and underwritten by, private insurance programs, be offered via private for-profit programs. Bottom line: just when a professional counselor figures out what is going on and begins to feel comfortable about what he or she is doing, the whole system and respective organizational infrastructures may change. Further adding to the stress of the counselor will be his/her lack of knowledge and background that makes changes in billing and marketing easy to do. Counselors may find themselves at the mercy of MBA's who open counseling shops where counselors work as contract employers with no benefits.

Spiraling concerns for accountability in the 1990s indeed may put professional counselors in the new millennium into a situation whereby they spend less time working with clients and more time justifying and documenting what they are doing. As people trust each other less and less, especially when tax dollars and prepaid insurance premiums are at stake, proving one's efficiency and effectiveness will be necessary for survival. Educational programs will have to provide hands-on training in the skills of accountability. Having these skills will not only decrease the counselor's stress level, but also will add to the credibility of the entire profession.

Remaining abreast of rapidly changing and expanding content and process information will constitute a tremendous challenge for the professional counselor in the new millennium. A professional counselor indeed will have to carefully plan to maintain his or her educational standards and knowledge base. For example, when you come back from vacation, you may find out that you missed a very important in-service, continuing education program on a new medical program and/or that all of the forms and procedures for your agency or company have been radically changed. Professional counselors will have to remain alert to this potentiality and make arrangements to prerecord information that they will need. Professional counselors will be spending more time after hours reviewing and listening to educational disks and reviewing videos. The days of "time off for training" and

"paid conferences" are seldom seen in today's workplace and probably will be considered ancient history in the new millennium. Furthermore, the past decade most certainly suggests that as a society we will continue to be more and more litigious. As the new millennium emerges, counselors will need to be sure that their "Legal Update/Impact" software programs automatically interface with their "Case Recording and Documentation" software programs. Professional counselors also will do well to obtain some training in courtroom demeanor and professional performance as they are going to be called more frequently to the stand to testify.

How specific aspects of "life in the new millennium" and "life in health care in the new millennium" will collectively and interactively impact the life of the professional counselor in the new millennium will be illustrated in the following tongue-in-cheek snapshot of one day in the life of a professional counselor in the year 2010.

A DAY IN THE LIFE OF MARIA FERNANDEZ: ANY FRIDAY, 2010

It is a Friday, the year is 2010, and for Maria Fernandez, the day begins very early. It is important to note, that Maria completed her master's degree in counseling two years ago and she recently received her license as a mental health counselor (LMHC) and her certification as a Internationally Certified Internet Therapist (ICIT). Maria is **B**ilingual, she speaks **E**nglish and **S**panish, and is fluent in **A**merican **S**ign **L**anguage (**B-S/E/ASL**). She took sign language to fulfill her language requirement at the university since Spanish was her first language and she already was fluent in both English and Spanish. Two months ago, she began working as a therapist for International Star Trek Associates (ISTA), and now that her probationary period has been successfully completed, she is a Certified Provider (CP). In the *International On-Line Provider Directory*, Maria is listed as: "CP/B-S/E/ASL #156341392–a LMHC, ICIT with ISTA."

The alarm goes off at 6:00 a.m., and by 6:15, Maria is on her stepmaster for her 20-minute aerobic workout. While exercising, Maria watches an in-service video training tape on "E-mail Brief Therapy Techniques." Upon completing her workout, she downloads her workout data onto her Office Data Base; her company offers its

employees a 2 percent monthly bonus if they verify that they are working out three days per week and not smoking cigarettes.

After a shower and a small carton of breakfast concentrate, Maria spends 30 minutes on her computer returning e-mails to six of her 22 clients for whom she provides therapy over the Internet. (One of her clients thanked her for the helpful video she sent to him entitled "Defeating Occupational Stress and Anxiety)". From 8:00 to 9:00, Maria logs on to her Supervision Chat Room for her weekly supervision session. Before leaving her house, she downloads her e-mail tracking and supervision log-on time for purposes of documenting the activities for her district manager. Also before leaving, Maria schedules a video-phone intake interview with an Asian-American client just assigned to her (she now has 43 Asian-American clients on her caseload; 32 of them speak English, three use American sign language, one speaks Spanish, and seven communicate through computer translation). Betty, the new referral from her district intake specialist, was diagnosed as having a Borderline Personality Disorder (with a long history of hospitalization). Maria is excited about having a borderline on her caseload–it carries a 3.6 difficulty rating which helps her monthly billing totals; on the downside, Betty's history of hospitalizations may threaten Maria's monthly 3 percent bonus for not having any hospitalizations for the month. Maria already has been approved for three sessions with Betty and is excited about the scheduled interview two weeks from next Tuesday from 2:00 to 2:50 p.m.

Maria, armed with her two high resolution personalized alpha pagers, leaves in her van, fully equipped with a cellular phone with voice mail, call waiting, FAX and computer modem capabilities, and her portable refrigerator which keeps her natural juices, salads, and fruits cool as she never has the time to stop for lunch. During the day, Maria has appointments at three rehabilitation centers, four depositions at attorneys' offices, and three marketing meetings at mental health hospitals. Hoping to be back home by 6:00 p.m., Maria believes that she will be able to download all of her mileage and visitations data (verified by the engine shut offs linked to SATNAV grid coordinates) as well as her registered phone consults and FAX transmittals. Currently in second place as ISTA's "CP of the Month," which comes with an additional 1.5 percent monthly bonus, Maria reflects on her successful day and thinks, "On days like this, I'm sure glad to have

received my bachelor's degree with a major in business and minor in computer science." [*Aside:* Now if she could just find a nice man who would take care of her child and fix dinner... and rub her swollen, aching feet and wrists (she fears that she is getting carpel tunnel syndrome).]

CONCLUDING COMMENTS

There most certainly will be many exciting and very rewarding aspects to life in the new millennium. The opportunities for living and enjoying a great life are boundless. But, as constant vigilance is the price of freedom, *self-awareness, self-monitoring,* and *internal self-control* will be the price for living and enjoying a great life–especially as a professional counselor.

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EPILOGUE

Now that you have read these 10 chapters, it is safe to assume that you are overwhelmed! Simultaneously appreciating and understanding the evolutionary development, current status, and future perspectives of counseling, managed care and privatization, special and assistive technology, ethical issues, systems trends, client populations, diversity, internationalization, and the personal side, the human side of being a professional counselor, indeed is overwhelming. Nonetheless, it must be remembered that the future is now, and you, the reader, are professional counseling's future.

According to the U.S. Census Bureau report released in September, 1998, an estimated 43.4 million Americans had no health insurance in 1997–up 1.7 million from 1996. Should this trend continue, who will attend to the health needs (and counseling needs) of Americans in need of them? At this time, the insurance industry most certainly is the strongest player at the table. Witness the vice-grip managed care currently has on our counseling profession! As we transition into the next millennium we no longer can merely trust that if we do good things for people in need we will be appreciated, respected, valued, and continued. Jerry Rubin, one of the "Chicago Seven" charged with instigating a riot outside the 1968 Democratic National Convention while protesting the Vietnam war, wisely offered, "The power to define the situation is the ultimate power." As we transition into the next millennium, who will define the situation for health care in general (and mental health specifically) ultimately will have the power. Professional counseling dare not passively stand by and watch what *they* do.

"I used to be a professional counselor," "I used to be a professional social worker," and "I used to be a professional psychologist," three people recent said. The fourth said, "Yeah, I know, and now we're all providers." We professionals have been stripped of our professional-discipline identities and replaced with an industrialist title. Thus, not only has the situation in which we work been defined, we have been defined.

Fighting, yes fighting, for our professional survival, as well as our own occupational/personal survival, will be sin qua non in the next millennium. Battles we cannot afford to lose. It is with pride and confidence that we offer this book and the work of our colleagues as a worthy launching pad for the proactive initiatives necessary for the battles ahead.

C.G.D. AND W.G.E.

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